The Mexican Migrant Mothers' Health Miracle

By

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Master's Project: Training Curriculum

A training curriculum presented to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master's in Public Health in the Department of Maternal and Child Health.

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Approved by:

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The Mexican Migrant Mothers' Health Miracle

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I soulfully dedicate this work with all my love and admiration to my mother, Ana Lourdes De la Garza, M.B.A. and my grandfather Roberto De la Garza, M.D..

I also dedicate this work and its benevolent ripple effects to all the women and mothers who gloriously exemplify resilience and bring light forth into this world.

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Diego Huerta
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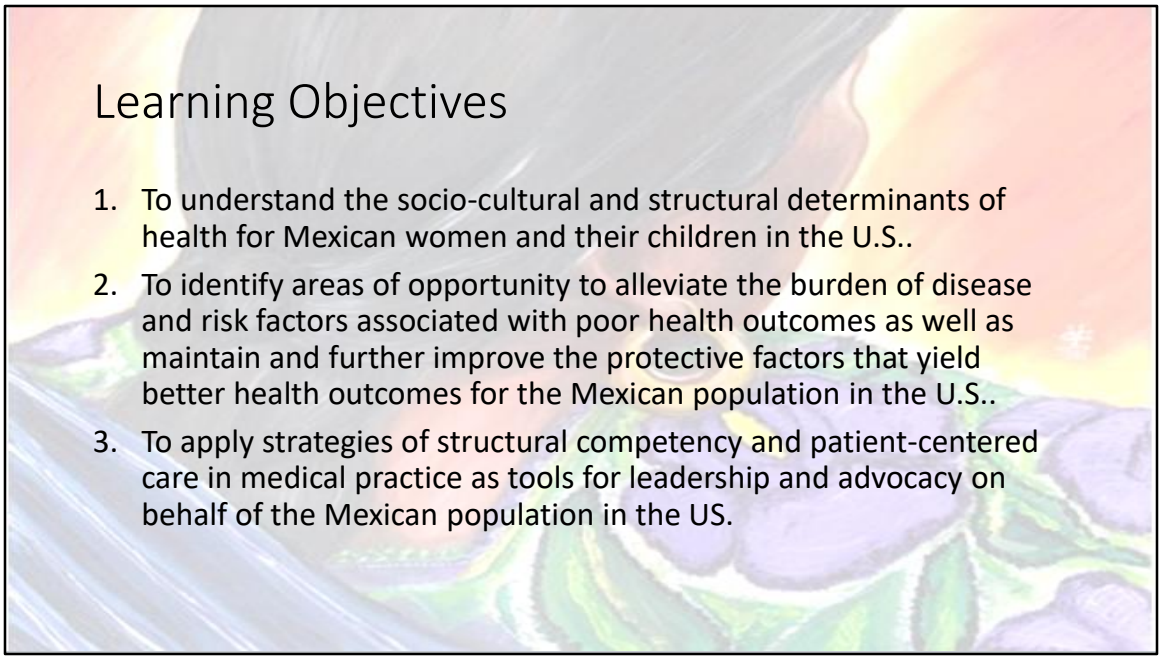
The artist was born in Michoacán, Mexico. He now resides in Durham, North Carolina.
Website: http://corneliocampos.web.unc.edu/



This training's philosophy uses a strengths-based approach as a sustainable interdisciplinary public health intervention to address life course health challenges for the immigrant Mexican population in the US.

This training curriculum will assist practitioners to qualitatively and quantitatively improve service provision to the Mexican population, especially women and children. Additionally, this training focuses on capacity building through structurally competent tools on how to implement culturally relevant interventions that sustainably bridge the gap between surviving and thriving.

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Competencies

- Evaluate the main theories underlying the study of the migration-health relationship, and apply these theories to the understanding of the current health issues experienced by the Mexican population in the US.
- Outline the major maternal and child health issues currently faced by the Mexican immigrant population in the US and utilize theories on the migration-health relationship to explain health outcomes among immigrants and disparities in health between Mexican immigrants and US-born populations.
- Discuss the historical and political context of contemporary health disparities for Mexicans living in the U.S., including their roots in biased systems and policies.
- Implement inter-disciplinary approaches to evaluate health through the medical anthropology lens, human rights lens, and economic return on investment lens related to the resolution of health inequities.
- Articulate and apply concepts and principles of social justice and ethical ideals to health policy and practice.

This training is experiential and interactive. Every module contains content that focuses on activities, contextualized interventions, and tools for practitioners dedicated to serve historically marginalized populations in general and the Mexican population specifically.

The training will consist of 3 modules. The first module will focus on Culture in regards to the Migrant Mexican population. The second module will focus on Intersectionality in order to contextualize the content of the Health Paradox. The third module will focus on Sustainability so that practitioners have tools to implement and move forward with evidence-based best practices.

At the start of the training, the trainer must do 2 things:
1) Thank the practitioners for their service and commitment to improve quality of life for vulnerable populations.
2) “Norm the room” with the following best practices:

“Encourage contributions from everyone and give voice to individuals and constituencies not in the room. Keep in mind that those in the room may need to serve as translators for stakeholders who are not present.

Acknowledge the impact of power and privilege on who speaks and who listens in groups. This means attending to the status that is accorded to a person because of her or his position, skin color, ethnicity, economic class background, sexual orientation, gender, religion, ability/disability, health, age, education, expertise, and/or profession.
Practice respect for others. Practicing respect for others does not mean abandoning our own opinions, assumptions, or judgments. It means knowing we have them and discerning when to hold them lightly and when to voice them. This is where deep listening is helpful.
Appreciate the constructive value of conflict, which is essential to growth.
Be open to breaking the rules and stepping outside the norm. Notice when another's "deviant" choices may be of benefit to the whole." (University of Minnesota, Center for Spirituality and Healing, p.34)

Then, ask if anybody has any additional rules before you start the training.

Reference:

Whole Systems Leadership. (2009). University of Minnesota. Center for Spirituality and Healing. Driven to Discover. Life Science Foundation.
Available at:
http://wsh.csh.umn.edu/leadership%20rlo__sq.php?runningtitle=Whole%20Systems%20Leadership&AUD=CSH&QUIZ=1&SCORE_REPORT_URL=https%3A//www.csh.umn.edu/education/focus-areas/whole-systems-healing/whole-systems-healing-leadership

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Cornelio Campos

Social Construction

- (Mis)representation due to fear and othering → Repetition → Toxic Normalization
- Example:
  - Mothers and children are usually seen as dependents of the state and men.
    - By virtue of being dependents, they are relayed to have weak power.
- Importance of visibility and representation
- Danger of a single story: incomplete version of the truth

Activity: Use poll everywhere application or facilitate class discussion with the following question: “When you think of Mexican culture, what comes to mind?”/ “What do you know to be true about the Mexican migrant population?”/ Has that changed over time? If so, reflect on how your perspective has evolved.
The facilitator should unpack the answers and invite participants to have an open mind as well as be compassionate and non-judgmental as we move forwards with the content.

May this section serve as an introduction to the our population of interest. First, let’s build a foundation with some background and statistics.

In order for health interventions to be effective and sustainable, a critical analysis of the social construction of the target population is needed. Social constructions are defined as stories that are repeated for so long that they become a normal part of the narrative and therefore so ingrained in the collective psyche that policy is made and maintained according to the collective stereotypical perception of their worth (Schenieder & Ingram, 1993).

Even though the Universal Declaration of Human Rights protects them, mothers and

children are usually seen as dependents of the state and men. By virtue of being dependents, they are relayed to have weak political power. Women have been socially constructed in a dichotomy delegating them as saints or sinners, which is only exacerbated by misogynistic and xenophobic stereotypes if they belong to a racial or ethnic minority. This double-bind of being too much and not enough has rendered them subject to abuse and neglect. Throughout history, women have faced discrimination in the economic, political, and social realms, which has limited their power and control over their bodies, minds, and futures.

Additionally, the social construction of immigrants is often a negative one. However, depending on the level of organization, immigrants despite their minority status may have strong political power, making them contenders on the system when voicing their struggles and demanding rights. Their representation is increasing in visibility, which translates into pressure for the government to produce effective public policy that can respect, protect, and fulfill their human rights. When combined, the social construction of women and immigrants reveals the layers of historical amnesia, discrimination, and oppression due to fear of the socially constructed 'other.' This intersectionality is an opportunity for action at the institutional level to prove our collective priority for equity and justice.

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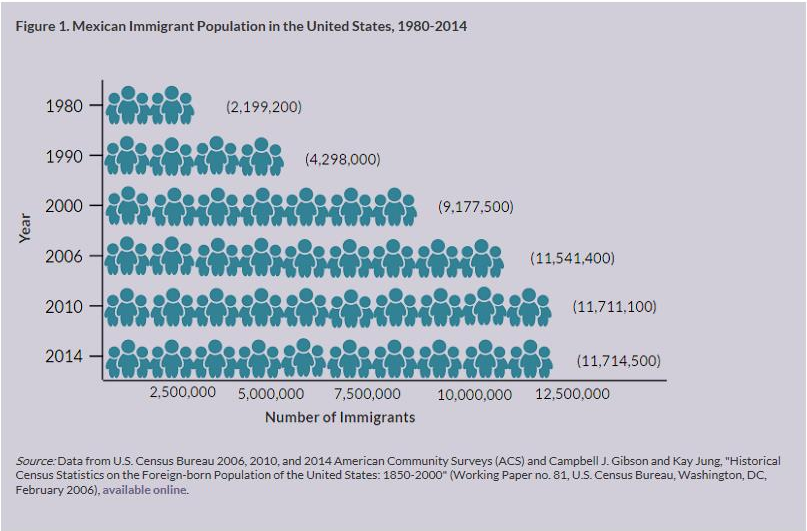
UN General Assembly, 1948. Article 25 of The United Nations Declaration of Human Rights.

Photo credit: Diego Huerta
Photographer born in Mexico. Resides in Texas.
Website: http://behindmystories.com/

Population Dynamics in terms of Immigration



In order to move forward, first we need to know where we stand in terms of population dynamics.

This presentation will utilize the term Latinx, which acknowledges the intersectionality of experiences of people of all genders (and gender non-conforming people) with Latin American descent. The term is gender neutral and recognizes the diversity of heritages.

Today, the Latinx community makes up 17.1% of the total US population and is projected to reach 28.6% by 2060 (Stepler & Brown, 2015).

Let's disaggregate the data.
The most recent statistics, reveal that "35% of Hispanics of Mexican origin were born in Mexico. And while the remaining two-thirds (65%) were born in the U.S., half (52%) of them have at least one immigrant parent." Additionally, "today, 11.4 million Mexican immigrants live in the U.S., making them the single largest country of origin group by far among the nation's 40 million immigrants" (Gonzalez-Barrera & Lopez, 2013). These statistics are an approximation to the actual numbers; still, they aid in the calculation of how many Mexicans are in need of care and do not have access to

health care due to politics of stigmatization and documentation.

According to the latest statistics from the Pew Research Center (2015) using the best available government data from both countries, “more Mexican immigrants have returned to Mexico from the U.S. than have migrated here since the end of the Great Recession (June2007-June 2009).” Additionally, “the overall flow of Mexican immigrants between the two countries is at its smallest since the 1990s.” These immigrants cite family reunification as the prime motivation to return to their roots. It is worth noting that “over the past decade, immigration from China and India to the U.S. has increased steadily, while immigration from Mexico has declined sharply.”

Let’s unpack the data by gender:
The number of migrant women has been increasing since the 1965 Immigration Act, which facilitated family reunification. “Female immigrants represent 51 percent of the overall foreign-born population, with 21.2 million immigrant women residing in the United States in 2013, out of a total immigrant population of 41.3 million” (Ruiz & Batalova, 2015).

It is worth noting that even compared to other countries, the US--the top immigrant destination for those pursuing the American dream--has the highest “female share of the immigrant population.” Data from the U.S. Census Bureau’s 2013 American Community Survey (ACS), found that 47% of women among all U.S. immigrants were from Mexico. This means that Mexican women represent the largest female immigrant group in the U.S. (Ruiz & Batalova, 2015).

References:

Ruiz, AG., Zong, J., Batalova J. (2015) Immigrant Women in the United States. Migration Policy Institute. Available at: http://www.migrationpolicy.org/article/immigrant-women-united-states

Gonzalez-Barrera, A., Lopez, M.H. (2013). A Demographic Portrait of Mexican-Origin Hispanics in the United States. Pew Research Center-Pew Hispanic Center. http://www.pewhispanic.org/files/2013/05/2013-04_Demographic-Portrait-of-Mexicans-in-the-US.pdf

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Gonzalez-Barrera, Ana,. (2015). More Mexicans leaving than coming to the U.S.. Pew

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Population Dynamics in terms of Births

- Births have surpassed immigration as the main driver of the dynamic growth
  - One out of four babies was categorized as Latinx in 2008
- Between 2000 and 2010, there were 9.6 million Latinx births in the U.S., while the number of newly arrived immigrants was 6.5 million
  - If the maximum capacity of a school bus is 72 children, that means that the US had about 133,333 buses full of newborns between 2000 and 2010, literally driving past immigration as the primary form of population growth
- Mexican-Americans comprise 63% of the overall Latinx population and of those 12.4 million or 39% identify as newcomers
  - While only representing 10% of the nation's population in 2008, 16% of the nation's births were to Mexican-American mothers

In order to understand the general patterns of what drives population growth, at a micro and macro level, it is essential to analyze fertility, mortality, and migration as well as their combined role in shaping population dynamics.

According to a report by the Pew Hispanic Center, "births have surpassed immigration as the main driver of the dynamic growth in the U.S. Hispanic population." In actuality, the overall annual births in the U.S. are disproportionately Hispanic, especially after taking into consideration that one out of four babies was categorized as Latinx in 2008. The Hispanic population of the United States grew from 35.3 million in 2000 to 50.5 million in 2010; this dramatic increase principally came from births.

The same report revealed that within the subcategory of Mexicans, there were fewer new immigrant arrivals in the 2000s (4.2 million) than in the 1990s (4.7 million). Even though there were slightly fewer arrivals, the population still continued to grow rapidly, with births accounting for 63% of the 11.2 million increase from 2000 to 2010. This birth increase imposes a public health challenge in terms of ensuring the next generation's quality of life in terms of access to culturally relevant and structurally competent care. Mexican-Americans comprise 63% of the overall Latinx population and of those 12.4 million or 39% identify as newcomers. Those

newcomers are the ones who enjoy superior birth outcomes the most because they figuratively carry tradition with them in order to survive the journey and cope in the host society. Moreover, it is worth noting that while only representing 10% of the nation's population in 2008, 16% of the nation's births were to Mexican-American mothers.

"Between 2000 and 2010, there were 9.6 million Latinx births in the U.S., while the number of newly arrived immigrants was 6.5 million" and given the projections, history will repeat itself for this current decade (Stepler & Brown, 2015). In other words, in true social math fashion, if the maximum capacity of a school bus is 72 children, that means that the US had about 133,333 buses full of newborns between 2000 and 2010, literally driving past immigration as the primary form of population growth.

This means that we need for equitable health system transformation in order to provide quality care and achieve health equity.

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The Mexican-American Boom: Births Overtake Immigration. (2011). Pew Research Center. Pew Hispanic Center. http://www.pewhispanic.org/files/reports/144.pdf.

Stepler, R., Brown, A. (2015) Statistical Portrait of Hispanics in the United States, 1980-2013. *Pew Research Center: Hispanic Trends.* http://www.pewhispanic.org/2015/05/12/statistical-portrait-of-hispanics-in-the-united-states-2013-key-charts/

Demographic Characteristic: SES

- Mexican immigrant families endure
  - Higher levels of food insecurity
  - Limited English proficiency
  - Low educational attainment
  - Stressors related to legal status and the climate of reception in the host community
- 52% of Mexican immigrant women lived in low-income families
- Cumulative health insults
  - Causal variables of poor health outcomes

Socioeconomically, in 2012, 52 percent of Mexican immigrant women lived in low-income families, characterized as living below the 150 percent of the U.S. federal poverty level. In order to further understand and address that need, contributing challenges that go along being uninsured and living in poverty must be understood. Mexican immigrant families endure "higher levels of food insecurity, limited English proficiency, and low educational attainment, as well as stressors related to legal status and the climate of reception in the host community" (Leite et al., 2013). All of these challenges are considered cumulative health insults and causal variables leading to detrimental mental and physical health outcome in the long term.

Reference:

Leite, P., Angoa, A., Castaneda, X., Felt, E., Schenker, M., Ramirez, T. (2013). Health Outcomes of Mexican Immigrant Women in the United States. Migration Policy Institute. Available at: http://www.migrationpolicy.org/article/health-outcomes-mexican-immigrant-women-united-states

Photo credit: Diego Huerta

Demographic Characteristic: Insurance

- Mexican women have the lowest levels of health insurance coverage of all ethnic groups in the US
  - 29% covered through employer-based health insurance
  - 14.7% covered through public medical insurance
- Stages of delay (Thaddesus & Maine, 1994).
  - Making a decision to seek care
  - Arriving to health facility/provider
  - Receiving quality and adequate care

In terms of health insurance coverage, at 54.6% "Mexican women have the lowest levels of health insurance coverage of all ethnic groups in the United States" (Leite et al., 2013). When linked to the typical low-wage occupations they hold, their status seems dire because these jobs are not only low paying but seldom offer benefits. This is an opportunity for workplace exploitation and occupational hazards that go unnoticed since most women work in the agricultural and service industries. Actually, only 29% of Mexican women are covered through employer-based health insurance. In comparison, coverage through employer-based health insurance looks like this: native-born non-Hispanic white women (70.6 percent), other immigrant women (57.6 percent), and U.S.-born black women (49.1 percent).

In regards to public coverage of medical insurance, the Migration Policy Institute revealed that 14.7% of Mexican migrant women are covered. In comparison, native-born non-Hispanic white women (10.4 percent), other immigrant women (12.4 percent), and U.S.-born black women (23.1 percent) are covered, which only reinforces the stereotype of minorities being delegated as dependents of the state and therefore a burden (Leite et al., 2013).

It is worth noting that access to public benefits is conditional.

Here are the rules according to healthcare.gov, under the section of “Immigrants and Medicaid & CHIP”:
“Immigrants who are “qualified non-citizens” are generally eligible for coverage through Medicaid and the Children’s Health Insurance Program (CHIP), if they meet their state’s income and residency rules.”

Further, “in order to get Medicaid and CHIP coverage, many qualified non-citizens (such as many LPRs or green card holders) have a 5-year waiting period. This means they must wait 5 years after receiving "qualified" immigration status before they can get Medicaid and CHIP coverage. There are exceptions. For example, refugees, asylees, or LPRs who used to be refugees or asylees don’t have to wait 5 years.”

The website describes that the term “qualified non-citizen” encompasses:
-Lawful Permanent Residents (LPR/Green Card Holder)
-Asylees
-Refugees
-Cuban/Haitian entrants
-Paroled into the U.S. for at least one year
-Conditional entrant granted before 1980
-Battered non-citizens, spouses, children, or parents
-Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
-Granted withholding of deportation
-Member of a federally recognized Indian tribe or American Indian born in Canada

Under the section of “Medicaid & CHIP Coverage for Lawfully Residing Children and Pregnant Women:”
“States have the option to remove the 5-year waiting period and cover lawfully residing children and/or pregnant women in Medicaid or CHIP. A child or pregnant woman is "lawfully residing" if they’re "lawfully present" and otherwise eligible for Medicaid or CHIP in the state.”

Here is a link for a list of states providing Medicaid or CHIP coverage to lawfully residing children and/or pregnant women:
https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html

Under the section of “Getting emergency care”
“Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but don’t have an eligible immigration status.”

Under the section of “Medicaid, CHIP, and “public charge” status:”
“Applying for Medicaid or CHIP, or getting savings for health insurance costs in the Marketplace, doesn’t make someone a "public charge" This means it won’t affect their chances of becoming a Lawful Permanent Resident or U.S. citizen. There’s one exception. People receiving long-term care in an institution at government expense may face barriers getting a green card.”

Due to these restrictions with the additional cost of out-of-pocket ER care, many women choose to delay care in terms of prevention, diagnosis, treatment, or management, sometimes until it is too late to intervene (Safer et. al., 1979). The stages of delay play an important role in decision making and action taking. First, the decision to seek care represents a delay depending on the perceived accessibility and quality of services. This perception is informed by previous personal experience or word of mouth. Second, reaching the facility represents a further delay when distance, transportation, and costs are considered. Receiving quality care is the ultimate delay, which is driven by poorly staffed and equipped facilities as well as inadequate management that makes judgments based on biased notions of worth and deservingness. Above all, the principal deterrent may be fear of the health system, which systematically includes and excludes people implicitly as well as explicitly.

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Leite, P., Angoa, A., Castaneda, X., Felt, E., Schenker, M., Ramirez, T. (2013). Health Outcomes of Mexican Immigrant Women in the United States. Migration Policy Institute. Available at: http://www.migrationpolicy.org/article/health-outcomes-mexican-immigrant-women-united-states

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Thaddeus S, Maine D. Too far to walk: Maternal mortality in context. *Social Science & Medicine*. 1994;38:1091-1110.

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Photo credit: Diego Huerta

Demographic Characteristic: Fertility & Fecundity

- The median age
  - 25 for Mexicans in the US
  - 30 for non-Mexican-origin Hispanics
  - 32 for Blacks
  - 35 for Asians
  - 41 for Whites
- In the age range of 40 to 44
  - The typical Mexican-American woman has given birth to 2.5 children
    - Nearly as many children on average as their counterparts living in Mexico
  - 2.0 children for Black woman
  - 1.9 children for non-Mexican-Hispanic woman
  - 1.8 children for White woman
  - 1.8 children for an Asian woman

Collectively, Mexican migrant women are more likely than non-migrants to be in their prime child-bearing years and have a desire to have more children. The median age of Mexican-Americans in the US is "25, compared with 30 for non-Mexican-origin Hispanics, 32 for blacks, 35 for Asians and 41 for whites."

Comparatively, youth gives them a fertility advantage over other major racial and ethnic groups within the US. "The typical Mexican-American woman ages 40 to 44 has given birth to 2.5 children, compared with 1.9 children for the typical same-aged non-Mexican-Hispanic woman, 1.8 children for the typical same-aged white woman, 2.0 for the typical same-aged black woman and 1.8 for the typical same-aged Asian woman."

The fact that Mexican-American women are having more children than the average same-aged white woman is foretelling of the changing demographics and future needs of the country that will need to through public policy accommodate and embrace the change in order to prevent and alleviate health inequities.

Interestingly, there is only a disparity in births between racial and ethnic groups within the US. In fact, there no discord between Mexican women in the US versus

Mexican women in Mexico. In reality, “Mexican-American immigrant women ages 40 to 44 have nearly as many children, on average, as their same-aged counterparts living in Mexico—2.7 versus 2.9.” The age and fertility variables represent the two key demographic indicators that reveal the reason for their high proportion of births and their better health outcomes.

In reality, every woman regardless of age or cultural protective factors is at risk during pregnancy because not everything can be planned. Usually, pregnant women are allocated into the high or low risk categories during antenatal appointments. However, a woman cannot be allocated into any category without previous consultation, “Mexican born women are less likely to receive antenatal care in the first trimester of pregnancy than other immigrants and US born whites.” Since these women typically do not have access to professional services in accordance with allopathic ideology (mainstream medicine) in a critical period of pregnancy, they rely on other forms of care to guide them through the birth continuum, such as alternative medicine. As with any health condition, early detection is usually the determining factor in saving lives. The fact that women are not in the health system receiving care through wellness visits is worrisome and a major barrier to improving the health outcomes.

Reference:

National Population Council of the Government of Mexico and the University of California. (2010). Migration & health: Mexican immigrant women in the U.S. Mexico, D.F.: Consejo Nacional de Población.

Photo credit: Diego Huerta

Epidemiologic Profile: Mexican Migrant Women

- Less likely to undergo the onset of serious chronic conditions like cardiovascular issues, cancer, hypertension, and asthma.
- Prone to diabetes, peptic ulcers, and musculoskeletal problems.
  - More likely to develop diabetes during pregnancy
- One out of every five suffer from musculoskeletal problems
- Less likely to have medical supervision and more likely to self-medicate

To understand the scope of migrant women's advantages and disadvantages, a binational collaboration was conducted in order to estimate the incidence, prevalence, risks, and opportunities of the Mexican population in the United States. The National Population Council report commissioned by the government of Mexico reinforced the already existing body of literature documenting that Mexican migrant women have better health outcomes in comparison to other immigrant and U.S. born women. Despite their socioeconomic level and low rates of health insurance and actual utilization of health care services, these women consistently displayed better health outcomes. Specifically, Mexican migrant women were less likely to undergo the onset of serious chronic conditions like cardiovascular issues, cancer, hypertension, and asthma.

However, their cultural protection did not make them immune to diabetes, peptic ulcers, and musculoskeletal problems. For example, nearly one out of every five Mexican migrant women suffers from musculoskeletal problems leading to gradual loss of mobility accompanied with intense pain, which may be caused by posture, work, and carrying heavy loads without proper protection. These conditions, both curable and chronic, overshadow the protective factors and require short and long term management.

Without proper monitoring, there is an increased risk of complications that contribute to morbidity, decreased quality of life, and mortality. Continuous monitoring can only happen when women have access to health clinics that budget for a sliding scale of prices, bilingual referrals, and shorter bureaucratic intake processes. Unfortunately, since “Mexican migrant women are less likely to have medical supervision and more likely to self-medicate,” they confront a bigger challenge in terms of prevention in allopathic ideology.

References:

National Population Council of the Government of Mexico and the University of California. (2010). *Migration & health: Mexican immigrant women in the U.S*. Mexico, D.F.: Consejo Nacional de Población.

Photo credit: Diego Huerta

Epidemiologic Profile: Children of Mexican Migrant Women

- Mothers deliver fewer low birth weight babies and lose fewer babies to all causes during infancy than do women of other ethnic groups (Magana et al, 1995).
- Less likely to suffer from migraines, headaches, asthma, and lower disability levels
- Children are more likely to suffer from malnutrition given the incidence of anemia, diarrhea and colitis
- Children of the least acculturated mothers demonstrate fewer
  - Well-child visits, increased emergent visits, and lower levels of immunization completeness

The National Population Council report found that children of migrant families were less likely to suffer from migraine or headaches as well as asthma. Additionally, they report lower disability levels. Even though self-reporting is an issue that may not accurately portray reality, there is a chance that the definition of disability does not coincide with the mainstream categorization and stigmatization of individuals in the US. However, children are more likely to suffer from malnutrition given the incidence of anemia, diarrhea and colitis. Anemia is a main micronutrient problem due to iron deficiency; however culturally relevant dietary interventions can reclaim traditional foodstuffs such as spinach and beans as a low-cost strategy. In addition, the obesity epidemic does not discriminate against these children since they are susceptible to excessive weight gain as well due to their Americanization. This may be because of their adoption of sedentary lifestyles, convenience of fast foods, and lack of safety in their neighborhoods, which deters them from outside playtime and vigorous physical activity.

In comparison to more acculturated mothers, a study by Clark found that in “quantitative analyses of medical records, children of the least acculturated mothers demonstrated fewer well-child visits, increased emergent visits, and lower levels of immunization completeness.” This study shows the consequences of stages of delay

at the micro level and the repercussions of a health system that is not responsive to the need of the most vulnerable whom it's supposed to protect. Since the positive health outcomes have an expiration date, it is important to create a safety net through the health as a human right and social good intervention in a competent and sensitive manner to incentivize utilization, observance, and follow-up of health services. Overall the epidemiological profile of the health status of Mexican migrant women and their children reveals the perils of acculturation. Indeed, acculturation may be a survival strategy; however, it comes at a sacrificial cost of their health. Therefore, the health care system should provide a clinical environment where children and their caregivers (especially their parents) can thrive, and not only survive. This demands respect, protection, and fulfilment of their human right to health. At the same it is worth considering the economic return on investment of providing equitable and quality health care access as a social good.

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Clark L. Mexican-origin mothers' experiences using children's health care services. West J Nurs. Res. 2002;24: 159–179.

Photo credit: Diego Huerta

Module 1: Culture

Photo credit: Cornelio Campos “Realidad Norteña”

What is culture?

- Who we are and what we are made up of
  - The water in which you swim in
  - The air we breathe
  - An iceberg
  - An onion
- Definition
  - Multi-dimensional
  - Dynamic
  - Omnipresent/pervasive
  - Never static nor fixed
  - Not uniform

Activity: Close your eyes and think about who has the biggest influence in your lifestyle choices and your health. This person or persons are your cultural gatekeepers because they influence the way you understand, prioritize, and act through expectations and examples. Keep your eyes closed and think about those who see you as a cultural gatekeeper. Be mindful of the messages (values, norms, beliefs, customs, ways of being including attitude and bias) that you are sending, reinforcing, and normalizing. Homework: reconsider your cultural repertoire. Use the magic of tidying up framework proposed by Marie Kondo: Ask yourself does this (fill in the blank) bring me joy/is it kind/is it useful?

Culture is an ever-changing constellation of ideals. According to the Dutch psychologist and sociologist, Geert Hofstede, "every person carries within patterns of thinking, feeling, and potential acting which were learned throughout the lifetime." These patterns can lead to ethnocentrism, which is the biased belief that one's own culture is superior when compared to others. This belief affects interactions in the micro to macro level. When these beliefs affect treatment then dignity and quality are jeopardized in the health care delivery system.

Please remember two things in your practice:

1) Presenting insights about culture does not necessarily lead to solutions because it may lead to stereotyping.
2) There are also cultural differences within groups not only between groups.

Reference:

Hofstede, G. (2011). Dimensionalizing Cultures: The Hofstede Model in Context. Online Readings in Psychology and Culture, 2(1). http://dx.doi.org/10.9707/2307-0919.1014

Photo credit: Diego Huerta

Context to the Content

- Concept of **I**-llness
- Concept of **We**-llness

- "To be rooted is perhaps the most important and least recognized need of the human soul." Simone Weil

Isn't it ironic that when we dissect the word illness, it starts with the letter "I." However, when we dissect the word wellness, it starts with the letters "w-e"?

A sense of community shifts our perspective from isolation and hopelessness to inclusion and acceptance. This sense of belonging is vital in the healing process. So much so that let's take a look at some numbers about how does the feeling of connection translate into a health outcome, the most sensitive of them all: birth outcomes.

Photo credit: Diego Huerta

Infant Mortality Rate

- Most sensitive indicator of population health
  - Associated with factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices.
- The primary risk factor for infant mortality is
  - Incidence of low birth weight infants (i.e., less than 5 pounds, 5 ounces) (Romero, Duke, Dabelea, Romero, & Ogden, 2012).
- Infants born to U.S.-born Mexican women exhibit rates of mortality that are statistically equal to those of non-Hispanic white women during the first weeks of life (Hummer, 2007).

Babies are the canaries in the coal mine. An easy way to understand how statistics play out in reality is with this quote by the co-founder of the Migration Policy Institute, Kathleen Newland: “No cold statistic expresses more eloquently the difference between a society of sufficiency and society of deprivation than the infant mortality rate.”

The health of the babies is revelatory since they are the most vulnerable sector of the population and therefore most sensitive indicator in population health (CDC, 2013). According to the CDC, infant mortality is an important indicator of the health of a nation or community because it is associated with factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices.

The first 28 days of life – the neonatal period – is the most vulnerable time for a child’s survival (UNICEF).
For comparison, in 2015, Hispanic women in the United States had a median neonatal mortality rate of 3.6, per 1,000 births while the incidence is 7 in Mexico; 8.2 in Peru; and 13.4 in Guatemala, 9.8 Nicaragua, 8.3 El Salvador, 25.4 Haiti, 21.7 Dominican Republic, 8.5 Colombia, 4.9 Chile, 6.3 Argentina. Although these statistics may lead

you to believe that migrating women are healthier than their compatriots, they also may reflect the general environmental and economic disadvantages of mothers in Latin American countries compared with mothers in the United States.

References:

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Hummer RA, Powers DA, Pullum SG, Gossman GL, Frisbie WP. Paradox Found (Again): Infant Mortality among the Mexican-Origin Population in the United States. *Demography*. 2007;44:441-457.

UNICEF. UNICEF Data: Monitoring the Situation of Children and Women. Current Status + Progress. Available at https://data.unicef.org/topic/child-survival/neonatal-mortality/

CDC Grand Rounds. (2013). Public health approaches to reducing U.S. infant mortality." *Centers for Disease Control and Prevention*. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6231a3.htm>.

Photo taken during an American Red Cross Emergency Relief Effort in Pearl, Mississippi.

Table A. Infant, neonatal, and postneonatal deaths and mortality rates, by race and Hispanic origin of mother: United States, 2013 linked file

Hispanic origin and race of mother	Live births	Number of deaths			Mortality rate per 1,000 live births		
		Infant	Neonatal	Postneonatal	Infant	Neonatal	Postneonatal
Total[1]	3,932,181	23,446	15,893	7,553	5.96	4.04	1.92
Non-Hispanic white	2,129,196	10,766	7,119	3,647	5.06	3.34	1.71
Non-Hispanic black	583,834	6,488	4,355	2,133	11.11	7.46	3.65
American Indian or Alaska Native	45,991	350	189	161	7.61	4.11	3.50
Asian or Pacific Islander	265,673	1,082	794	288	4.07	2.99	1.08
Hispanic	901,033	4,507	3,200	1,308	5.00	3.55	1.45
Mexican	545,202	2,672	1,911	761	4.90	3.51	1.40
Puerto Rican	68,302	405	289	115	5.93	4.23	1.68
Cuban	18,854	57	43	14	3.02	2.28	*
Central and South American	131,305	565	410	155	4.30	3.12	1.18

Healthy People 2020 was launched on December 2, 2010. It provides a science-based, ambitious, yet achievable, 10-year agenda for improving the nation's health. These are national science-based goals for health promotion and disease prevention to improve the health of all the people living in the US. The agenda is established every ten years to "encourage collaborations across communities and sectors; empower individuals toward making informed health decisions; and measure the impact of prevention activities." The vision "is a society in which all people live long, healthy lives," which is in total congruence with the international human rights instruments extolling health as a human right.

In terms of maternal and child health, the target outcome is 6.0 infant deaths per 1,000 live births. This would be a 10% improvement from 2006 when the IMR was 6.7 deaths per 1,000 live births (Office of Disease Prevention and Health Promotion).

Given the statistics in the graph above, it is evident that white and Mexican babies have reached the national target outcome. Mexican babies are doing better that white babies. So the learning opportunity here is two-fold: 1) Let's maintain and further improve these healthy health outcomes to be cost effective and cost efficient in both the short and long terms. 2) Let's take the lessons learned contextually up to

scale and apply best practices to other populations. For example, African American babies are at 11.11 deaths per 1,000 live births. This is ethically unacceptable and a public health failure.

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Healthy People 2020. Office of Disease Prevention and Health Promotion. (2016). About Healthy People. Available at https://www.healthypeople.gov/2020/About-Healthy-People

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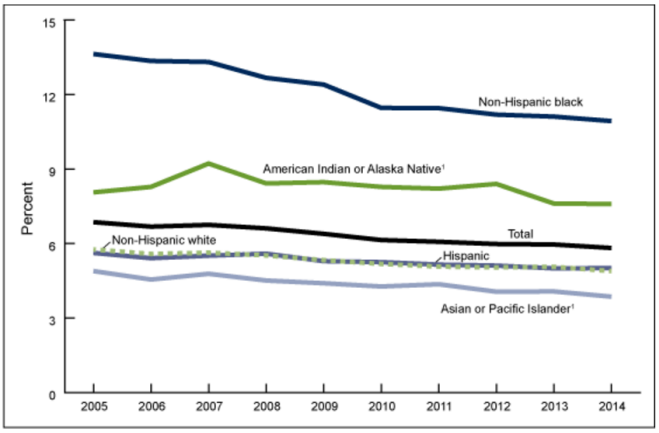
Office of Disease Prevention and Health Promotion. Healthy People.gov. Healthy People 2020. Maternal, Infant, and Child Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives

Figure 1. Infant mortality rates, by race and Hispanic origin of mother: United States, 2005–2014



[1]Includes persons of Hispanic and non-Hispanic origin.

NOTES: For "Total" and each race and Hispanic-origin group, the decline in the rate for 2005–2014 is statistically significant ($p < 0.05$).

Access data table for Figure 1 .

SOURCE: NCHS, National Vital Statistics System.

In March 2017, the CDC reported the trends in infant mortality in the United States during the period of 2005-2014.

Good news: infant mortality rates have declined over the past decades. Let's take a closer look at the disaggregated data.

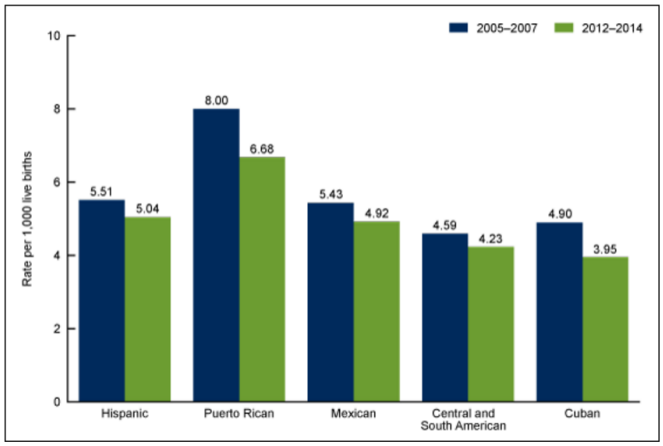
Some noteworthy points:

1. "From 2013 to 2014, only infants of non-Hispanic white women had a decline in the infant mortality rate (3%). Declines among other race and Hispanic-origin groups were not statistically significant."
2. "From 2005 through 2014, the rate declined 21% for infants of Asian or Pacific Islander (API) women (from 4.89 to 3.86 per 1,000) and 20% for infants of non-Hispanic black women (from 13.63 to 10.93)."
3. "Infant mortality rates declined 15% for infants of non-Hispanic white women (from 5.76 to 4.89) and 11% for infants of Hispanic women (from 5.62 to 5.01)."
4. "From 2005 through 2014, infants of both non-Hispanic black and American Indian or Alaska Native (AIAN) women had the highest mortality rates (10.93 and 7.59, respectively, in 2014)."

Reference:

Centers for Disease Control and Prevention. (2017). National Center for Health Statistics. Trends in Infant Mortality in the United States, 2005-2014. Available at: https://www.cdc.gov/nchs/products/databriefs/db279.htm

Figure 2. Infant mortality rates, by Hispanic-origin subgroup of mother: United States, 2005–2007 to 2012–2014



NOTES: For each Hispanic-origin subgroup, the decline in the rate from 2005–2007 to 2012–2014 is statistically significant ($p < 0.05$).

Access data table for Figure 2 .

SOURCE: NCHS, National Vital Statistics System.

The same CDC report gives more good news in regards to infant mortality rates among Hispanic subgroups. Overall, the mortality rates declined from 2005-2007 to 2012-2014.

Some noteworthy points are:

1. "The largest declines in the infant mortality rates among Hispanic subgroups from 2005–2007 to 2012–2014 were observed among infants of Cuban (19%) and Puerto Rican (17%) women."
2. "From 2005–2007 to 2012–2014, the infant mortality rate declined 9% for infants of Mexican women (from 5.43 to 4.92 per 1,000) and 8% for Central and South American women (from 4.59 to 4.23)."
3. "For both 2005–2007 and 2012–2014, infants of Puerto Rican women had the highest infant mortality rate among the Hispanic subgroups. The mortality rate for this subgroup was 47% higher than among infants of Mexican women (the subgroup with the second highest rates) for 2005–2007 and 36% higher for 2012–2014."

Reference:

Centers for Disease Control and Prevention. (2017). National Center for Health Statistics. Trends in Infant Mortality in the United States, 2005-2014. Available at: https://www.cdc.gov/nchs/products/databriefs/db279.htm

2013 NORTH CAROLINA INFANT MORTALITY REPORT, TABLE 4

Infant Death Rates and Annual Percent Changes by Race/Ethnicity

	Total Rate	% Change	White Non-Hispanic Rate	% Change	Af. Am. Non-Hispanic Rate	% Change	Am. Ind. Non-Hispanic Rate	% Change	Other Non-Hispanic Rate	% Change	Hispanic Rate	% Change
Year:												
2009	7.9	-3.7	5.5	-8.3	15.8	7.5	9.5	-38.3	2.8	-33.3	5.7	-5.0
2010	7.0	-11.4	5.3	-3.6	12.7	-19.6	7.5	-21.1	4.3	53.6	5.0	-12.3
2011	7.2	2.9	5.5	3.8	12.9	1.6	8.6	14.7	4.0	-7.0	5.4	8.0
2012	7.4	2.8	5.5	0.0	13.9	7.8	12.3	43.0	4.8	20.0	4.2	-22.2
2013	7.0	-5.4	5.5	0.0	12.5	-10.1	11.0	-10.6	5.0	4.2	3.7	-11.9

Infant Deaths (under 1 year of age) per 1,000 live births.

Source: NC Department of Health & Human Services State Center for Health Statistics, 15SEP2014

Here is a case example. The Public Health Division of the North Carolina Department of Health and Human Services released North Carolina's Infant Mortality Rate Report. Without disaggregating the data, the IMR for 2013 was 7.0 per 1,000 live births. The Infant Mortality Rate in 2010 was the lowest in North Carolina's history.

However, we have a public health crisis with the African American non-Hispanic population. Their infant mortality rate was 12.5 deaths per 1,000 live births. Remember that the Healthy People 2020 goal is 6 deaths per 1000 live births. Unfortunately, black babies have twice the mortality rate that what the national goal is. However, this number is the lowest in the NC history, revealing a pattern of health inequity. This is a racial health disparity given that the African American non-Hispanic populations have an infant mortality rate 2.3 times higher than the White non-Hispanic population.

Reference:

NC Health and Human Services. Infant Mortality Statistics for North Carolina. Vital Statistics. North Carolina State Center for Health Statistics. Available at: http://www.schs.state.nc.us/data/vital/ims/2014/

Latinx Health Paradox

- Why a "paradox"?
  - Counterintuitive to ideology of wealth predicting health
- Resilient to injurious health effects and health insults
- Experience better physical health and lower mortality
  - All Hispanics combined enjoy more longevity than Whites (the gold standard control group)
- Despite challenges & risks
  - Low SES
  - Obesity, diabetes
  - Neighborhood segregation
  - Poor access to quality health care: undiagnosed and late-stage diagnosed diseases
  - Discrimination

The video above is part of a documentary series called Unnatural Causes: is inequality making us sick? This clip is part of episode 3 called "Becoming an American."

The epidemiological paradox of Latinx health is an observation that reveals that "despite higher poverty rates, less education, and worse access to health care, health outcomes of many Hispanics living in the United States today are equal to, or better than, those of non-Hispanic whites" (Morales, 2002).

This phenomenon has been known as the Hispanic or Latinx Paradox, which was first analyzed by Markides in 1986 in the southwest. This was considered counterintuitive because of the prevailing wisdom about wealthier people being healthier. Wealth is typically associated with high levels of education, income, and housing standards; yet, Latinx especially those of Mexican origin, have better than expected health outcomes.

Markides' observations pioneered a series of studies that attempted to understand the differentiation in Latinx sub-groups and their corresponding advantageous behavioral patterns or lack thereof. Specifically, they encountered that in terms of infant mortality, life-expectancy, mortality and morbidity from cardiovascular diseases

and major types of cancer, as well as measures of mechanical health (physical function) there was significant statistical evidence to conclude that elusive protective factors were present. However, on other quality of life health indicators like diabetes and infectious and parasitic diseases, Latinx are at higher risk relative to their white counterparts (Markides and Coreil, 1986).

The most evident disconnect is revealed in data based on vital statistics that show the greatest mortality advantage. All Hispanics combined enjoy more longevity than non-Hispanic Whites. However, the advantage is greatest among older people (Markides & Escbach, 2005).

Similar to non-Hispanic Blacks, Latinx experience a range of psychosocial and physical health challenges due to their socio-economic positionality. These factors are: high rates of poverty, neighborhood segregation, discrimination, poor healthcare access, and high rates of obesity, diabetes, and undiagnosed and late-stage diagnosed diseases. Despite such risks, Latinx people generally experience better physical health and lower mortality than non-Hispanic Whites, the standard control/comparison group. Given the body of literature documenting their health success against all odds, attention now turns to the sources of such resilience (Ruiz, 2016). This is where practitioners can learn from this population's best practices in order to reinforce the strengths to maintain and further improve outcomes in this community.

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Markides KS, Eschbach K. Aging, migration, and mortality: current status of research on the Hispanic paradox. J Gerontol B Psychol Sci Soc Sci. 2005 Oct;60 Spec No 2:68-75. Review. PubMed PMID: 16251594.

Markides KS, Coreil J. The health of Hispanics in the southwesten United States: an epidemiologic paradox. Public Health Rep.1986 May-Jun; 101(3): 253-265. PubMed PMCID: PMC1477704.

Ruiz JM, Hamann HA, Mehl MR, O'Connor M. The Hispanic health paradox: From epidemiological phenomenon to contribution opportunities for psychological science. *Group Processes & Intergroup Relations*. 2016;19:462-476.

Morales, L. S., Lara, M., Kington, R. S., Valdez, R. O., & Escarce, J. J. (2002). Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes. Journal of Health Care for the Poor and Underserved, 13, 477-503

Unnatural Causes: is inequality making us sick? (2008). Episode 3: Becoming an America. Califronia Newareel with Vital Pitures. Available at:

http://www.unnaturalcauses.org/episode_descriptions.php?page=3

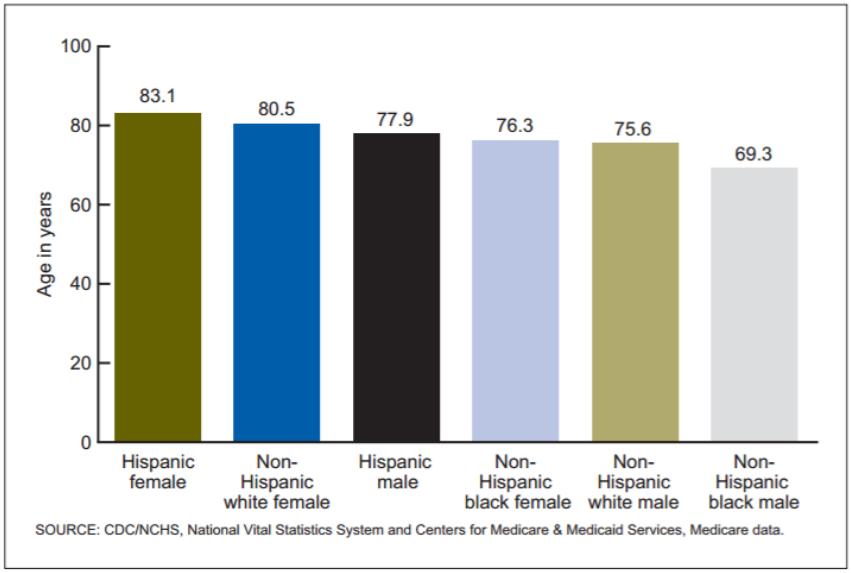

Figure 6. Life expectancy at birth, by Hispanic origin, race, and sex: United States, 2006

Let's look at life expectancy at birth in terms of ethnicity, race, and sex in 2006.

Reference:

Arias E. United States life tables by Hispanic origin. National Center for Health Statistics. Vital Health Stat 2(152). 2010. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_152.pdf

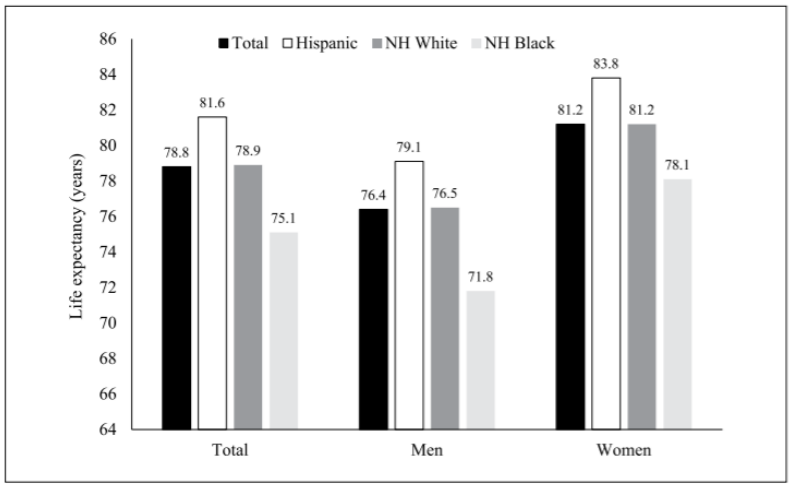

Figure 1. Racial/ethnic differences in life expectancy (in years) for a person born in 2013. Note that Hispanics have a greater life expectancy among total, men, and women and that the widest disparity is between the life expectancy of Hispanic women and NH Black men (12 years).
Source: Centers for Disease Control and Prevention (CDC, 2015).

Now let's look at the racial and ethnic differences in life expectancy for a person born in 2013. Still as revealed in the slide before, Latinx have a greater life expectancy among latinx, whites, and blacks regardless of sex.

From Ruiz et al. (2016) article:

"Although Hispanics experience higher incidence of diabetes, viral-mediated cancers, and various communicable diseases, they experience significantly lower rates of the major causes of death, including heart disease, stroke, all-site cancers, and infant mortality compared to non-Hispanic Whites" (NHW; Heron 2015; Mozaffarian et al., 2015; Siegel et al., 2015).

It is important to keep in mind that Latinx are a "diverse community representing over 22 countries of origin and with significant heterogeneity in behaviors, diet, and traditions. However, what often binds Hispanics together is a common language and values of collectivism and interpersonal harmony" (Oboler, 1995).

Given the fact that "collectively, the U.S. Hispanic population exceeds 55 million with 65% native to the US (Lopez & Patten, 2015). With Hispanics accounting for over 50%

of the nation's annual population growth (Colby & Ortman, 2015)." This is an opportunity for health systems transformation where practitioners can capitalize on the protective factors that enable these healthy outcomes and make them sustainable as well as replicable for other populations.

References:

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Lopez G., Patten E. (2015). The impact of slowing immigration: Foreign-born share falls among 14 largest U.S. Hispanic origin groups. Washington, DC: Pew Hispanic Center. Retrieved from http://www.pewhispanic.org/files/2015/09/2015-09-15_hispanic-origin-profiles-summary-report_FINAL.pdf

Table A. Selected demographic and socioeconomic characteristics by Hispanic origin subgroup and race for the non-Hispanic white and non-Hispanic black populations

	Hispanic									Non-Hispanic	
Demographic characteristics	Total	Mexican	Puerto Rican	Cuban	Dominican	Spaniard	Central American	South American	Other Hispanic	White	Black
Population estimate[1]	45,432,158	29,318,971	4,127,728	1,572,138	1,249,471	454,299	3,592,810	2,544,070	2,572,671	198,420,355	36,397,922
Percent of total population	15.1	9.7	1.4	0.5	0.4	0.2	1.2	0.8	0.9	65.9	12.1
Percent of Hispanic population	100.0	64.5	9.1	3.5	2.8	1.0	7.9	5.6	5.7	...	...
Median age[1]	27.4	25.7	29.0	41.4	29.4	36.1	29.5	34.1	27.3	40.8	31.9
Percent aged 65 and over[1]	5.5	4.3	6.9	19.0	6.2	12.3	3.8	7.1	7.9	15.5	8.6
Total fertility rate[2]	3.0	3.1	2.2	1.6	---	---	[3]3.0	[3]3.0	---	1.9	2.1
Infant mortality rate[4]	5.4	5.3	8.0	5.1	---	---	[3]4.5	[3]4.5	---	5.6	13.4
Percent U.S. born[1]	60.9	61.2	([5])	39.3	41.0	84.3	33.4	31.1	83.2	96.1	92.3
Percent foreign born[1]	39.1	38.8	([5])	60.7	59.0	15.7	66.6	68.9	16.8	3.9	7.7
Socioeconomic characteristics											
Percent with bachelor's degree or higher[1]	12.6	8.7	15.3	25.3	14.9	28.7	11.3	30.6	16.4	30.4	17.2
Median family income in U.S. dollars[1]	43,240	41,350	43,578	52,978	36,245	64,749	43,101	54,435	49,011	70,399	41,567
Poverty rate[1]	18.9	20.5	21.3	10.7	25.0	9.4	16.3	10.0	15.2	6.1	21.2

... Not applicable.

--- Data not available.

[1]Figure is the average of 3-year estimates from the American Community Survey data collected January 2006–December 2008.

[2]Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2006. National vital statistics reports; vol 57 no 7. Hyattsville, MD: National Center for Health Statistics. 2009.

[3]Estimates are for Central and South American combined. Data is not available to estimate these indicators separately for the two groups.

[4]Mathews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth/infant death data set. National vital statistics reports; vol 58 no 17. Hyattsville, MD: National Center for Health Statistics. 2010.

[5]The Puerto Rican population is considered U.S.-born, whether born on the U.S. mainland or the island of Puerto Rico.

The National Center for Health Statistics published a report that included distinct average lifespan measures for white, black and Latinx.

"Despite reporting lower-than-average income and education — [Latinx} had the nation's longest average lifespan. On average, Latinx outlive white Americans by 2.5 years and black Americans by nearly 8 years" (Arias, 2010). This is a teaching/learning moment for our health system to be more equitable, efficient, and effective by monitoring and evaluating the root causes of this paradox, capitalizing on what works, expanding on best practices, and protecting those most vulnerable.

Reference:

Arias E. United States life tables by Hispanic origin. National Center for Health Statistics. Vital Health Stat 2(152). 2010. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_152.pdf

Latina Health Paradox

- Despite less education, less access to medical services, and later initiation of prenatal care
  - Previous strong consistent association between SES and birth outcomes (Singh & Yu, 1995).
- Lowest prevalence of LBW and are less likely to deliver LBW infants compared with Whites
  - Latinas also had a lower prevalence of SGA and lower odds for preterm birth compared with White women in NC (Brown, 2007).
  - Analogous paradox between foreign-born and US-born Latinas
    - FB lower risk for preterm birth, LBW, and SGA (regardless of documentation status) (Flores et al, 2012).
- However, the exact mechanism remains unknown.
  - Lack of uniformity among subgroups
    - Mexican and Central American greatest benefit
    - Puerto Ricans poorest health outcomes
    - Importance of stratifying Latinas by country of origin

The ‘‘Latina epidemiologic paradox’’ refers to the observation that despite socioeconomic disadvantages, Latina mothers in the United States have a similar or lower risk for delivering an infant with low birth weight (LBW) compared to non-Latina White mothers. An analogous paradox also exists between foreign-born (FB) and US-born (USB) Latinas (Hoggatt, 2012).

From Flores et al. (2012):
There is variation of the “Latina paradox” among Latinas according to birthplace, where U.S.-born Latinas do not experience better birth outcomes than Whites, but foreign-born Latinas experience better birth outcomes for several endpoints compared with U.S.-born Latinas.The results of the study indicate that outcomes were worse for the segment of the Latina population that was born in the United States and had greater education. This suggests that alternative strategies for this group are necessary to reduce adverse birth outcomes. These findings highlight the importance of stratifying Latinas by country of origin. Although foreign-born Latinas were more likely to experience “adverse” socioeconomic risk factors compared with Whites and U.S.-born Latinas, they had a consistently lower risk for preterm birth, LBW, and SGA than U.S.-born Latinas. Impressively, in their subanalysis among foreign-born Latinas only, the findings showed that undocumented women were

generally not at greater risk than documented women for LBW, preterm birth, or SGA, despite their lack of legal immigration status in the US. The authors used SSN as an indirect measure of legal status. Social support (particularly from the husband) and maternal social network size were positively associated with birth weight. Particularly foreign-born Latinas, may have healthier lifestyles (including better nutrition, lower rates of smoking and alcohol consumption) and possibly a higher regard for parental roles (Collins & Shay, 1994; Hedderson & Daudistel, 1982; Lethbridge-Cejku, Schiller, & Bernadel, 2004; Winkleby & Cubbin, 2004).

To be more specific at the state-level, in a study from North Carolina, Mexican-born Latinas experienced fewer medical risk factors and used less tobacco or alcohol during pregnancy. Despite having less education and lower access to prenatal care than USB Latinas, the prevalence of LBW was low (Leslie, 2006).

The term Latinx Paradox is misleading because not all Latinx enjoy the same benefits, since the only ones who exhibit the most protection are those of Mexican-origin who are women. In general, Mexican, Cuban, and Central-American women have the strongest advantages in birth outcomes, while Puerto Rican women have a less favorable profile with elevated numbers of low birth weight babies (McGlade, 2004).

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Superior Health Outcomes Despite Risk Factors

- Being among the most socioeconomically disadvantaged racial/ethnic populations in the United States (McGlade et al., 2004).
- "Twice as likely to receive late or no care at all as compared to non-Hispanic white mothers" (OMH, 2015).
- Higher use of preventive services than Hispanic men, but lower use of mental health care (Morales et al., 2002).

Activity: Use poll everywhere application or facilitate discussion with the following question: "In your experience, what are the risk factors that affect the health status of Mexican Migrant Mothers?"

The hypothesis used to explain the aforementioned superior health outcomes (despite the risk factors) is that social and cultural protective factors— maintained in immigrant communities by an informal system of care—are a substitute, at least in part, for formal prenatal care (McGlade et al, 2014).

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Unfounded Explanations

- Faulty census data
  - Misclassification of Hispanics as non-Hispanic
- Healthy immigrant effect
  - Selective migration pursued by most vigorous
- Salmon bias
  - Moribund migrant effect
    - Elderly or infirm immigrants return to die
      - Cause estimates of Hispanic mortality to be understated and would inflate life expectancy estimates

Although none of these explanations have been supported by data or research, it is important to recognize their existence.

For the healthy migrant effect, the “associations were weak, few health indicators were statistically significant, and there was substantial variation in the estimates between males and females and between urban and rural dwellers” (Rubalcava et al., 2008)

Regarding the salmon bias, according to Hummer “more than 50% of all infant deaths in the United States occur during the first week of life, when the chances of out-migration are very small.”

Regardless of the validity or statistical power of these explanations, it is important to consider the political and economic situation as well as its impact on immigration trends due to deportations and also the fear instilled in populations to the extent that it catalyzes voluntary return migration.

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Mexican Migrant Mothers' Health Paradox

- Lowest use of formal medical care (Morales, 2002).
  - Lower incidence of mental health disorders, cancer, cardiovascular disease, infant mortality and low infant birth weight
- Less likely to receive antenatal care in the first trimester of pregnancy than other immigrants and US born whites (Nat Pop. Council).
- Despite adverse SES profile, FB Mexicans had a lower prevalence of LBW compared to USB Mexican–American Latinas (Madan, 2006).

Regardless of the criticism and skepticism, the birth outcome data is consistent.

From the Kaestner, Robert, Jay A. Pearson, Danya Keene, and Arline T. Geronimus (2009) article:

"Poor Mexican immigrants often have better health than other poor people in the United States (Markides and Eschbach 2005). However, Mexican immigrants' health advantage is reduced with years of residence in the United States and disappears altogether in the next generation (Collins et al. 2001; Kaestner et al. 2009), perhaps as integration heightens the exposure to and impact of othering experiences (Viruell-Fuentes 2007)."

"As new immigrants reside in the United States longer, or as the progeny of immigrants are raised in the United States, they become aware of and attuned to U.S. racial hierarchies and ideologies and are vulnerable to the physiological impacts of racialized contingencies of social identity, such as the common suspicion that they are not legal residents of the United States or truly American (García 2004). Navigating such prejudices and stereotypes in daily interactions in integrated settings may activate physiological stress processes."

"The lower incidence of mental health disorders, cancer, cardiovascular disease, infant mortality and low infant birth weight among Mexican immigrants has been termed paradoxical because of this population's generally low socioeconomic status (SES), stress of adapting to a new country, language and other access barriers to health care associated with negative health outcomes (Markides & Coreil, 1986; Zsembik & Fennell, 2005)."

Despite their social construction and social determinants of health, Mexican migrant women and their children are beneficiaries of an unexpected phenomenon worthy of respect, protection, and fulfillment under the human rights framework.

Mexicans who are newly arrived to the United States carry with them a sense of culture, shared history, and a universal experience of surviving. As these newcomers settle into their new spaces, they try to maintain the traditions that made life worthwhile and the practices that helped them make sense of the world. It is worth mentioning that not every Mexican woman adheres to the same cultural mores, but if and when they do, they open a door of benefits in both the short and the long terms.

In particular, Mexican immigrants have found themselves outliers in the (physical and mental) symptoms of pursuing the American Dream. This epidemiological conundrum reveals the distribution of better health outcomes for the subgroup of Mexican immigrants when compared to their Anglo counterparts even though socioeconomically they fare worse than blacks (Markides & Coreil, 1986). This was considered counterintuitive because of the prevailing ideology about wealth predicting health. Wealth is typically a function of high levels of education, income, and housing; yet, culture has proven to be a more effective protective factor for this population. Moreover, "low SES Mexican immigrants appear largely immune to many of the injurious health effects of migration, poverty, racism, discrimination, and other factors that typically affect racial and ethnic minorities in the United States. More specifically, Mexicans have lower overall mortality rates than Whites on most major health indicators" (Morales, 2002).

Despite having all the exposures and risk factors that would normally produce poor pregnancy outcomes, Mexican women count on the protective factors of social support, familism, collectivistic society, value on personalismo (warm interpersonal relationships), healthy diet, and religion (Page, 2004). These cultural-specific traditions become advantages dependent on time and degree of acculturation.

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Explanatory Variables: Socio-cultural Mechanisms

- Informal system of community networks
  - Marianismo
  - Collectivistic society
  - Intergenerational knowledge transmission
  - Personalismo
  - Barrio Advantage
  - Respeto (valuing and including older network members)
  - Simpatía (valuing of interpersonal harmony)
  - Familismo
    - Stresses emotionally positive, supportive family relationships
    - Family obligation, family as a social referent, and family support
    - Fictive kinship
      - Compadrazco "godparenthood"

Activity: Use poll everywhere application or facilitate class discussion with the following question: "In your experience, what are the protective factors for Mexican Migrant Mothers' health status?"

Mexican women count on social support, age of being primi paras, familism, intergenerational knowledge transmission, collectivistic society, value on personalismo, healthy diet, religion/spirituality, marianismo (selfless devotion), and cuarentena (McGlade, Saha, Dahlstrom, 2004).

All of the factors above suggest a sociocultural mechanism for advantages in infant mortality.

For example, let's examine the surviving tradition of intergenerational knowledge transfer that instills morals and values. The mode of transmission is through stories, fables, and proverbs, which facilitate the bequeathing of advice from one generation to the next. Also, many mothers benefit from the support of extended family members especially grandmothers, mothers, sisters, and aunts. The tradition of women helping other women is very strong in Latin America, which makes it logical that these practices of collective strategies of survival transfer to life in the U.S.

(Guendelman & Chavez 1994).

In terms of intergenerational family expectations, the term 'familismo' refers to an individual prioritizing their tribe over themselves to a degree of self-sacrifice if necessary (Pole et al., 2008). This interdependence knows no limits since resources are shared unconditionally. On the other hand, familismo means keeping problems- including stress- within the buffer zone of the family unit, which reduces the chances of stigmatizing 'chisme' (gossip) and outside intrusion.

Family orientation, or familism, is a multidimensional construct emphasizing family support, solidarity, and obligations within the family (Updegraff, McHale, Whiteman, Thayer, & Delgado 2005). This cultural construct is so powerful that even a study of Mexican-American youth and their parents found that children who have a strong sense of familism are less likely to become involved with deviant peers over time (Roosa et al., 2011).

It is well-documented that low infant birth weight and infant mortality rates are lower for Latinx living in more ethnically dense enclaves or "barrios" (Shaw & Pickett, 2013; Shaw, Pickett, & Wilkinson, 2010). These environments tend to be economically disadvantaged, but culturally rich and thus thriving in health terms due to socio-cultural mechanisms that serve as protective factors.

From the Campos et al., (2008) article:

"For example, pregnant Latinas have been found to report highly positive attitudes toward pregnancy and motherhood and more support from the infant's father and family relative to others (Engle, Scrimshaw, Zambrana, & Dunkel-Schetter, 1990; Zambrana, Dunkel-Schetter, Collins, & Scrimshaw, 1999). Pregnant Latinas also report more frequent and satisfying interactions with family compared with other groups (Sagrestano et al., 1999)."

"Such support may mitigate the adverse effects of poverty through the pooling of resources (Sherraden & Barrera, 1996). It also may have a stress-buffering effect that improves the psychological and physiological milieu in which pregnancies occur. (Sherraden & Barrera, 1996 Poverty and family support). Whatever the mechanisms, mothers who have this support generally experience better birth outcomes than those who do not (Weigers, 2001)."

*Disclaimer: not every woman adheres to the same cultural mores, but if and when they do, they open a door of benefits in both the short and the long terms.
"Preferences for certain kinds of social support vary considerably, based on how each woman makes meaning of being pregnant. This diversity is one more piece of

evidence that minority cultures cannot be essentialized in health disparities research" (Fleuriet, 2009).

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Social Capital

- Social connections and their benefits
- Social integration is amongst the most robust psychosocial health moderators
  - Stress buffering
  - Tangible support
  - Communal coping
- Associated with values
  - Trust
  - Tolerance
  - Solidarity
- Contribution to wellbeing
  - Personal well-being
  - Health
  - Crime rates
  - Driver of economic growth → greater economic efficiency

Social capital is a productive social resource that helps actors achieve certain ends. It is both activity specific and context specific. Social capital is made up of systems of trust, reciprocity, obligation, and norms. Dynamics of social networks are dependent, provide support, and have normative influence (Colema, 1998).

From the Siegler, (2014) article:

“Social capital is important because of its positive contribution to a range of well-being aspects relevant to policy makers and researchers, such as personal well-being (Helliwell and Putnam, 2004; Helliwell, 2003), health (Veenstra, 2002 and 2000) and crime rates (Sampson, 2012; Sampson et al., 1997). These benefits occur at every level: individual, community, regional, national or even international (Halpern, 2000).”

“Social capital has been recognized as a driver of economic growth, resulting in greater economic efficiency (Putnam, 2000 and 1993; Fukuyama, 1995). At a macro-level, it is likely that higher levels of trust and cooperative norms reduce transaction costs, thereby driving productivity (Putnam, 2000 and 1993). At an individual level, people with wider social networks are more likely to be employed (Aguilera, 2002), to

progress in their career (Lin, 2001) and to be paid more (Goldthorpe et al., 1987)."

From the Ruiz et al. (2016) article:

"Social integration is amongst the most robust psychosocial health moderators (Holt-Lunstad, Smith, & Layton, 2010). Social integration serves as a key health-promoting process which affects health through a variety of social mechanisms (e.g., stress buffering, tangible support, communal coping). The processes described by this "sociocultural hypothesis" may affect health at each point in the disease course from initial susceptibility to survival in the context of advanced disease."

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Table 1: The Four Different Aspects of Social Capital

Aspect of social capital	Definition
Personal Relationships	This aspect of social capital refers to the "structure and nature of people's personal relationships" (OECD, 2013), and is concerned with who people know and what they do to establish and maintain their personal relationships.
Social Network Support	This refers to "the level of resources or support that a person can draw from their personal relationships" (OECD, 2013), but also includes what people do for other individuals on a personal basis.
Civic Engagement	This refers to "the actions and behaviours that can be seen as contributing positively to the collective life of a community or society" (OECD, 2013). It includes activities such as volunteering, political participation and other forms of community actions.
Trust and Cooperative Norms	This refers to the trust and to the cooperative norms or shared values that shape the way people behave towards each other and as members of society. Trust and values that are beneficial for society as a whole (such as for example solidarity and equity) can determine how much people in a society are willing to cooperate with one another.

Here are the four different aspects of social capital and how they operate.

From Veronique Sigler, (2014):

1) Personal relationships:

• Their sources, which are the places and context in which people meet each other.
• Their composition: 'Strong ties' (or 'bonding ties') describe the relationships of an individual with their closest circle of relatives and friends. 'Weak ties' (or 'bridging ties') relate to the connections of someone with acquaintances such as colleagues at work or neighbors. 'Linking ties' are the connections of a person with others of greater status, resources and power.
• The size of people's networks for the various types of relationships, for example, the number of close friends.
• Their diversity: the proportion of friends that are of different age, sex, religion, ethnic group, level of education or income than own.
• The type of contact: People can have face to face, telephone, letter or email contact.
• The frequency of contact

• The quality (or strength) of people's personal relationships and people's feelings about it.

2) Social network support:

• The perceived support, which is the support that people think they can draw from their relationships.
• The support received, which are the different types of resources an individual can receive from others, including emotional, practical or financial support, advice and guidance, and socializing.
• The support provided, including unpaid work (or informal volunteering), which is the help given by an individual to another individual on a personal basis.
• The frequency of support received or provided. Support can be available on a day-to-day basis or in times of crisis.

3) Civic engagement:

• Formal volunteering, which is defined as giving time, skills or service to a club, organization or association.
• Political engagement, which relates to active political engagement (such as taking part to a demonstration, attending a political meeting and signing a petition or voting in elections).
• Frequency of formal volunteering and political engagement
• Other civic-minded activities: they include donating money or other goods (food or clothes) to charities or non-profit organizations; donating blood; taking part in jury duty; participation to community events such as fetes, shows etc.
• Civic attitudes and beliefs: Interest in national or local affairs aside from direct action. This also includes people's perception of civic engagement.

4) Trust and cooperative norms:

• Trust in institutions, such as the national or local government, parliament, police force, justice system, press, etc.
• Trust in others: whether people think that generally speaking, most people (including strangers) can be trusted.
• Social values of cooperation: examples of such values include solidarity, helpfulness, honesty, generosity, politeness, equity, tolerance and non-discrimination towards people with differences based on ethnicity, language, culture, religion, nationality, sexual orientation, age or other characteristics. These are the fundamental norms that are beneficial for society as a whole, linked to fairness and inclusiveness, and which encourage people to cooperate.

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Ecomap/Sociogram Activity

Identifies:
*Members of the household and extended family
*Quality of relationships
*Relationships with community systems

Purposeful:
*Organizes information
*Identifies strengths as well as needs and weaknesses
*Can be used to represent past, present or future relationships

Here is an activity that has a dual purpose: mapping the distribution as well as the quality of social capital for yourself and others. The idea is that the client knows themselves better than anyone else, which makes them the best architect of their reality and destiny.

The ecomap is an assessment, planning, or intervention tool that focuses on an ecological approach to depict systems and their respective interactions. From its inception, an ecomap is a social work qualitative data collection tool that visually represents the interconnectivity and interdependence of an individual in a system (Bennett & Grant, 2016).

In micro social work, ecomaps are used to gather information and identify the following:

Members of the household and extended family
The quality of relationships among these individuals
The resources these relationships exchange with the client
The client's relationships with community systems
Other systems from which additional resources may be available

Ecomaps are useful tools because they:
Organize information
Identify strengths as well as needs and weaknesses
Can be constructed with an individual or with a family
Can be used to represent past, present or future relationships
Engage the client system in the process of assessing relationships with the social environment
Help to identify the client's positive contributions to the environment, possible resources for help, and gaps in support from the environment

Bennett and Grant suggest the following questions to consider when building an ecomap:
Regarding Self:
1. What do you consider to be your strengths?
2. What types of plans/hopes/dreams do you have for the future?
3. Whom do you admire? What do you admire about them?
4. What do you enjoy doing in your free time? Activities/Hobbies?
5. Identify aspects of your environment that are important to you.
6. What behaviors do you have that you like/do not like?
7. Can you describe some of the challenges you have of being you?

Regarding Interactions with Community and Friends:
1. Could you describe how often you visit with your friends?
2. How important are your friends – are they more or less important than your family?
3. What organizations do you belong to or participate in? For example, are you a member of a car
club or a church group?
4. What are some of your favorite pass times or what do you do when you “hang out”?

Regarding Family:
1. When I mention the word family to you, what comes to mind? Can you describe briefly the members of your family?
2. Do you get along with your family members? Is there one member of the family who influences you the most (positively)? Is there one family member who influences you in a negative way?
3. What is the language your family uses at home?
4. Are there challenges you/your family face?
5. What customs/holidays does your family celebrate or not celebrate?

6. What are some of the activities that you and your family do together formally—with in your community or with friends?
7. What are some activities you and your family do for fun?

Regarding School:
1. Do you go to school now?
2. Do you have a degree or certificate?
3. What do you want to do when you finish school (if you are still attending school)?
4. Is education important for achieving your goals?
5. Is school a positive experience for you? Negative?

Regarding Work:
1. Do you work now?
2. What is your favorite activity at work?
3. Is there an activity at work that you like the most?
4. If you could change your job or change your position at your present work, what do you wish you could do?

Here are some additional questions to ask yourself and/or your patient:

Who is included in the family unit and what is their positionality/power?
Where are the strongest relationships? Where are the weakest?
How does the sources of social support differ among members of the family unit?
What assumptions are you making?
Who are you leaving out/who are you including? How come?

References:

Bennett J, Grant NS. Using an Ecomap as a Tool for Qualitative Data Collection in Organizations. *New Horizons in Adult Education and Human Resource Development*. 2016;28:1-13.

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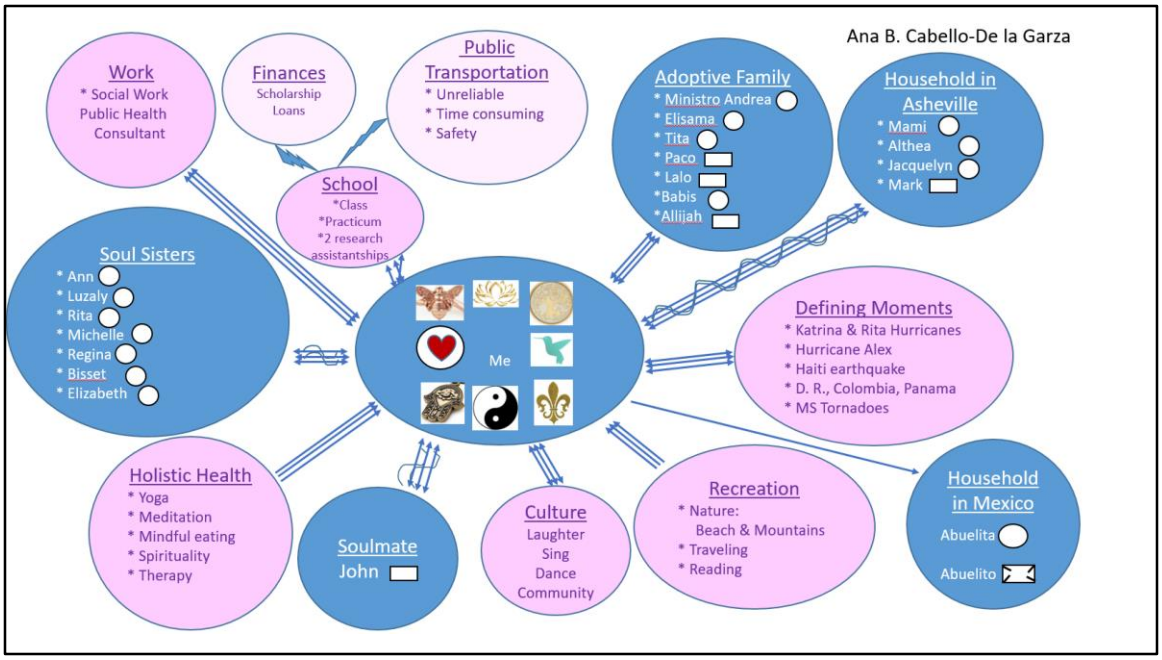
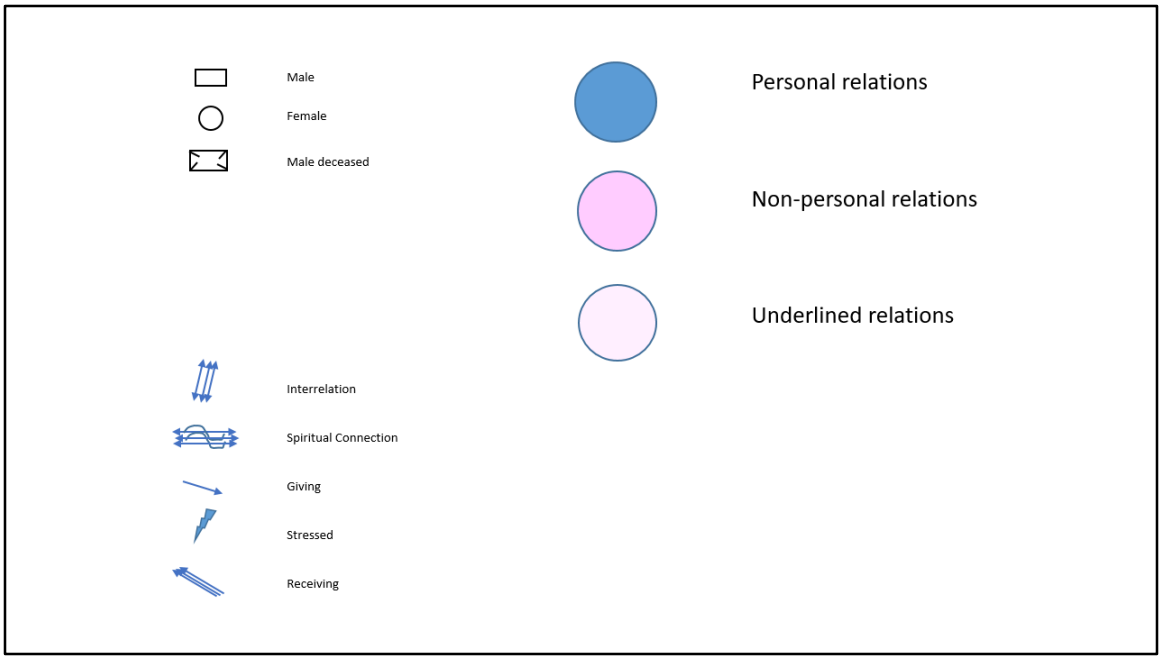


Here is an example of my own ecomap.

Please be mindful of how the client wants to designate placement and characterization of the realities in their ecomap. As a practitioner, you must non-judgmentally honor the way the client perceives their embeddedness in the systems they belong to. Bottom line, the client must be the architect and engineer of the relationships and their mapping. Be aware of how your privilege and socialization may lead you to adopt a biased and assumptive binary arrangement especially regarding gender. Remember that gender and sex are not synonymous and that experiences are conceptualized in a spectrum and/or continuum. So let's give the power of naming those experiences (and creating the symbols, which you both will use as reference) to the creator of the map (the client), who ultimately is the expert in their own life.



Here is the key to my ecopmap. Keys are essential to remembering the logistics of the ecomap. These can be put in the patient's file. A copy can also be given to the patient in order to be used as an interconnectivity reminder of the power of social capital.

All arrows indicate energy flow, depending on the strength of the relationship is the number of lines placed. For example, 3 lines with arrows describes the strongest of relationships.

Cultural Buffer Hypothesis

- Mexican-Americans are more likely to plan pregnancies than African-American women (52% vs. 25% of women)
  - Connected to the cultural expectation among Mexicans that having a child demonstrates one's femininity; fertility signifies womanhood (Zambrana et al, 1991).
- Stress buffering effects thanks to
  - Centrality of family
  - Religiosity
  - Spirituality
  - Hopefulness for the future "Ojalá"
- Yields lower levels of
  - Drinking
  - Smoking
  - Sexual risk taking

The socio-cultural mechanisms described above make up the cultural repertoire of Mexican Migrant women that when employed even if unpacked are qualitatively and quantitatively powerful. So much so that this social-cultural capital can be used as a prevention strategy.

From Horevitz, 2013 article:
"The cultural buffer hypothesis posits that aspects of traditional Latinx culture, in particular the centrality of family, seem to buffer stressful life circumstances that lead to the poor health outcomes experienced by other groups of similarly low SES (Hovey, 2000). Furthermore, religiosity (typically Catholicism) and spirituality have been associated with stress-buffering effects in Latinx adolescents (Wills, Yaeger, & Sandy, 2003), as well as lower levels of drinking, smoking, and sexual risk-taking particularly among Latina immigrant women and adolescents (Aranda, Castaneda, Lee, & Sobel, 2001; Bacallao & Smokowski, 2007; Caballero, 2005; Campos et al., 2008; Guendelman, Gould, Hudes, & Eskenazi, 1990) According to acculturation theory, however, the protective buffer of traditional Mexican culture diminishes with greater acculturation to mainstream U.S. society."

An analysis by Hovey (2000) "revealed that family dysfunction, geographical

separation from family, non-positive expectations from the future, and low income levels were significantly related to elevated levels of acculturative stress. However, family closeness, hopefulness for the future, and financial resources may provide a buffer against acculturative stressors experienced by migrating individuals and families."

In Spanish, the word "Ojalá" comes from Arabic "(law sha'a Allah)," which means "si Dios quisiera" or "if God wills it." This expression of a wish that is not yet real, but there is a possibility in the near future of it manifesting allows for hope to shine through in the surviving and thriving process.

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Photo credit: Diego Huerta

Expiration Date→ Public Health Crisis

- High support families were more likely to visit Mexico and send their daughters there to stay with relatives for vacations.
  - Women with low family support and poorer birth outcomes knew little to nothing about their parents' Mexican heritage.
  - Importance of strong sense of ethnic identity/heritage within a cohesive family unit (Sherraden & Barrera, 1997).
- Within one generation in the US, the influence of the Mexican diet is almost lost (Batis, 2011).
- Socio-cultural protection of preterm delivery disappears after 5 years in the US (Guendelman & English, 1995).
- Rates of low birthweight for Mexican-born mothers have been recorded as low as 3.9%
  - While second or third generation Mexican origin mothers born in the U.S. have a low birthweight rate of 6.1%. (Guendelman, Hudes, Eskenmazi, 1990).

Unfortunately, the benefits and socio-cultural mechanisms described in the past slides have an expiration date. The number of people affected by no longer being benefitted by the protective factors could lead to a public health crisis if nothing is done to prevent, maintain, improve, and expand them.

From the Horevitz & Organista, (2013) article:

"Perhaps the most robust support for the MHP comes from research on infant birth outcomes in California. Guendelman and colleagues (Guendelman, 1995; Guendelman & English, 1995; Guendelman et al., 1990; Guendelman, Thornton, Gould, & Hosang, 2006), among others (see, Acevedo-Garcia, Soobader, & Berkman, 2007; Bender & Castro, 2000; Campos et al., 2008; Harley & Eskenazi, 2006; Johnson & Marchi, 2009; Magana & Clark, 1995; Padilla, Boardman, Hummer, & Espitia, 2002; Scribner & Dwyer, 1989; Sherraden & Barrera, 1997; Weigers & Sherraden, 2001) have repeatedly found favorable birth outcomes (i.e., healthy birth weight) in first generation Mexican immigrants that disappear by the second generation."

A review by Rumbaut (1997) found that U.S.-born Mexican women tend to resemble U.S.-born Anglo women in terms of "worse dietary patterns (higher fat consumption,

reduced fiber & fresh produce consumption), increased likelihood for smoking and drinking during pregnancy, and less reported familial support."

Sherraden & Barrera (1997) found that "high support families were more likely to visit Mexico and send their daughters there to stay with relatives for vacations. In comparison, women with low family support and poorer birth outcomes knew little to nothing about their parents' Mexican heritage (i.e., where they were from in Mexico, etc.)." These findings support the social capital hypothesis that a strong sense of ethnic identity, a sense of belonging, and pride in a communal heritage within a cohesive family unit has a healthy role in birth outcomes.

From the Guendelman (1995) article:

"Differences in nutrient intake between first and second generation women of Mexican origin may also explain differences in birth outcomes. Guendelman and Abrams found that despite lower socioeconomic status among first generation immigrant women, their average intake of protein, vitamins and minerals involved in fetal development was higher than that of second generation Mexican American women. It appears that Mexican-born women of childbearing age adhere to a traditional Mexican diet, whereas the nutritional intake of second generation women born in the U.S. resembles the less healthy habits of non-Latinx whites."

In terms of substance abuse one generation can also make a difference. Vega et al. compared Mexican women with US.-born women of Mexican descent and found "that alcohol use during pregnancy increased from 6.7% to 7.3% and the rate of prenatal illicit drug use increased from .63% to 3.4%."

From Guendelman & English (1995) article

"The relation between US residence status and birth outcomes was examined, controlling for sociodemographic factors and maternal behaviors. Long-term immigrants who have lived in the United States for more than 5 years were more likely to deliver preterm infants (odds ratio (OR) = 1.9, 95% confidence interval (CI) 1.1-3.3) and low birth weight infants (OR = 1.5, 95% CI 0.8-2.7) than newcomers who have lived in the United States for 5 years or less. Long-term immigrants had higher parity, more pregnancy complications, and fewer planned pregnancies, and were more likely to smoke than newcomers."

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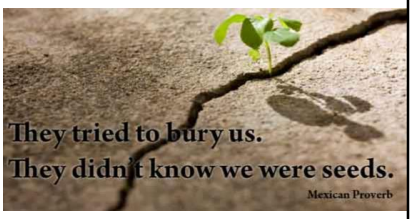
Vulnerability as a Weakness and a Strength

- Mothers who had low satisfaction with support during the 3rd trimester experienced more postpartum depressive symptoms by 6 weeks postpartum (Martinez-Schallmoser et al., 2003).
- "Nervios" as a manifestation of distress
- Immediately after delivery, both mother and newborn: "muy delicados"
  - May be confined to the house for 7 to 15 days, or until the first postpartum bath at 3 days postdelivery
- Support, validate, reinforce the importance of la Cuarentena
  - If not possible due to work or lack of support, then be careful with shaming or guilting



Let's remember the classic study done by Grossman, Eichler, and Winickoff (1980), which found that if a woman experiences the perinatal period as a crisis or stressful, she will be more vulnerable to difficulties with antenatal and postnatal adjustment and the transition to motherhood.

In terms of mental health vulnerability, Heilmann et al. (2004) found that pregnant and postpartum women of Mexican descent who grew up in the US are at particular risk for depressive symptoms. Especially, "pregnant and postpartum women of Mexican descent who live alone in the United States may be at particular risk for depressive symptoms." Interestingly, "women who spent all of their childhood years in Mexico before coming to the US had a lower level of depressive symptoms and more satisfaction with life than women who were exposed to the US in childhood" (Heilmann et al., 2002). Therefore, in practice please inquire about place of birth and allow for dialogue regarding where she spent her childhood years.

From Martinez-Schallmoser, 2005 article:

"In the traditional Mexican culture, vulnerability may cause the woman to complain of feeling nervous (los nervios), considered a culturally appropriate manifestation of

distress (Martinez-Schallmoser, 1992). During the labor and birth process, Latinas are traditionally assisted by helpers such as the mother, motherin-law, other female relatives, or la partera. They support and encourage the laboring woman to have a successful birth. Immediately after delivery, both mother and newborn are traditionally considered to be muy delicados (extremely vulnerable or delicate) and may be confined to the house for 7 to 15 days, or until the first postpartum bath at 3 days postdelivery (Spector, 2004). Rigid dietary and behavioral restrictions are traditionally followed by Mexican women during la cuarentena (the 40 days postpartum) that safeguard mother and newborn (Laganá, 2003). The rigid diet of la cuarentena is traditionally offset by extraordinary care, thoughtfulness, assistance with housework and child care, and individual attention and social support from the husband, extended family members, and friends. However, some women are unable to follow la cuarentena because they must work or are without the traditional support (Laganá, 2003)."

Therefore, in order to know when and how to support women who are vulnerable, familiarity with these beliefs is essential. Especially, being able to reframe vulnerability as a strength is very healing. Vulnerability allows for connection - an already existing central belief in the collectivistic Mexican ethos - which gives purpose and meaning to life. According to Brené Brown and her famous TED talk, "The Power of Vulnerability," vulnerability is the birthplace of "joy, creativity, belonging, love." Her explanation of how we must feel our feelings because we cannot selectively numb them, allows the patient to believe that to "feel this vulnerable means that they are alive." Therefore, using the therapeutic tool of reframing is useful to create a different perspective/vantage point.

Here is a link to her full talk:
https://www.ted.com/talks/brene_brown_on_vulnerability

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Heilemann MV, Lee KA, Kury FS. Strengths and Vulnerabilities of Women of Mexican Descent in Relation to Depressive Symptoms. *Nursing Research*. 2002;51:175-182.

Table 1. Varieties of Adaptation to Acculturation for U.S. Minority Groups.

Attempt to retain culture?	Positive predominant relations possible with dominant culture?	Form of adaptation
No	Yes	Assimilation
Yes	Yes	Integration
Yes	No	Segregation
No	No	Marginalization

Source: Berry (2003).

The cultural stress buffering hypothesis is threatened by the kind of adaptation pursued. To exacerbate that reality further, the type of vulnerability experienced also predicts health outcomes. In the graph above we can see how each form of adaptation either retains culture and/or adopts positive relations of new culture.

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Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), Acculturation: Advances in theory, measurement, and applied research (pp. 17-37). Washington, DC: American Psychological Association.

Acculturation

- Multi-dimensional phenomenon of adaptation
  - Conclusive detrimental effects on substance use, dietary patterns, and infant birth weight
- Not a simplistic causal relationship
  - Declining health over time depends on co-occurring variables
- Not inherently negative
- Need to look at sociopolitical & eco-developmental context

The health benefits previously described are time-sensitive since they erode over time as acculturation occurs. This may be due to differential exposures to stress due to institutionalized systems of oppression; allostatic load that measures the accumulated wear and tear on the body; and changes in lifestyle due to the survival strategy of becoming mainstream.

One form of adaptation is acculturation. According to Horevitz & Organista (2013) acculturation is a "culture change that is initiated by the conjunction of two or more autonomous cultural systems. This change is a byproduct of direct transmission, change of environment, or even reactive survival to traditional lifestyles."

In their article, they point out an assumption and overlooked flaw: "if the process of acculturation is as clear cut as it appears in large-scale studies, why does the relation appear to hold primarily for Mexicans rather than other U.S. Latinx groups? That is, if protective Latinx cultural values and norms are generally practiced across all major U.S. Latinx groups, why don't they seem to be buffered as well (e.g., Puerto Ricans)? Acculturation as a simple behavioral model from "Latinx" to "U.S." culture clearly cannot explain such inter-Latinx differences yet the majority of public health studies point to it as the explanation of health declines."

Another important point to consider is that acculturation should not be demonized or believed to have a causal relationship to all declining health outcomes (Weigers & Sherraden, 2011).
First, declining health over time also depends on other explanatory and co-occurring variables such as:
1. biological determinants of health
2. ecodevelopmental framework that explain the influence of contextual factors such as "ethnic enclaves neighborhood characteristics, family and social networks, ethnic identity, language use" (Lopez-Class 2011)
3. mezzo level (family, community)
4. macro level structural policy systems such as immigration law

Second, acculturation does not have to be inherently negative. It is highly dependent upon the conditions of acculturation for different groups. (Chun, Organista, & Marin, 2010). Actually, "depending on the measure used, acculturation can have a positive, negative, or neutral relation to health outcomes" (Lara, et al, 2004). Further, due to the lack of methodological uniformity, the only conclusions about the detrimental effects of acculturation were on substance use, dietary patterns, and infant birth weight.

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Weigers, M. E., & Sherraden, M. S. (2001). A critical examination of acculturation: The impact of health behaviors, social support and economic resources on birth weight among women of Mexican descent. International Migration Review, 35, 804-839.

Photo credit: Diego Huerta

Acculturation Stress

- Collective confusion and anxiety, loss of identity, feelings of alienation, and striking out against larger society
- Results from coping with daily difficulties, conflicts and strains experienced when trying to adjust to a new cultural system.
  - Risk for alcohol and drug use, aggressive behavior, and mental health problems
  - Heightened risk for antisocial behavior and psychopathology
  - Heightened by negative experiences such as racial or ethnic discrimination and coping with language barriers

Bacallao and Smokowski's article reveals that acculturation stress stems from coping to a new system that was not designed for the newcomer. This process and transition period has a heightened risk for detrimental mental and physical health. They further quote an intergenerational gap, "children commonly acculturate faster than adults, creating an acculturation gap between generations that precipitates family stress (Hernandez & McGoldrick, 1999; Szapocznik & Kurtines, 1980)"

From Horevitz & Organista (2013):

Berry and Annis (1974) defined acculturative stress as "collective confusion and anxiety, loss of identity, feelings of alienation, and striking out against larger society. More specifically, acculturative stress refers to behaviors and experiences generated during acculturation that are pathological and disruptive to the individual and ethnic group (e.g., deviant behavior, psychosomatic symptoms, and feelings of marginality)."

According to Berry (2003), "acculturative stress will be highest when the cultural and behavioral similarity between two groups in contact is lowest, and where pressure is placed upon the minority group to acculturate due to the dominant group's low tolerance for racial and cultural diversity. "

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Smokowski, P. R. (2011). *Becoming bicultural : risk, resilience, and Latino youth*. New York: New York University Press.

Berry, J. W., & Annis, R. C. (1974). Acculturative stress: The role of ecology, culture and differentiation. Journal of Cross-Cultural Psychology, 5, 382-406.

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Photo credit: Diego Huerta

Segmented Assimilation Theory

- Expansion from health acculturation perspective:
  - Understand structural drivers of health disparities
    - Discrimination
    - Legal barriers
    - SES
- Second generation
  - Exposure to "othering"
  - Incorporation to US stratification system
- Interaction between individual and contextual factors
- Anthropological tool:
  - Emic perspective from within the social group
  - Instead of etic from the perspective of the observer

From Horevitz & Organista, (2013):

"Segmented assimilation theory is an iteration of acculturation theory. This new theory focuses on the new (i.e., post-1965) immigration to the United States. Additionally, it focuses on the process by which the new second generation becomes incorporated into the US stratification system, with an emphasis on the interaction between individual (e.g., social capital) and contextual (e.g., discrimination, immigration policies, ethnic enclave characteristics, etc.) factors in determining "downward" or "upward" assimilation (Portes & Zhou, 1993; Zhou, 1997). Still we must remember that depending on the segment of the population considered and in which segment they enter, outcomes (positive AND negative) are highly variable."

"Some scholars criticize the health acculturation perspective for underestimating structural drivers of health disparities, such as discrimination, legal barriers, and low socioeconomic status" (Hunt et al. 2004; Viruell-fuentes et al. 2012).

The experience of reality of the next generation is tainted by "more experiences of discrimination and othering than did their immigrant parents." This is partly due to the lack of protective effects of residence in ethnic enclaves that the parents enjoyed.

Additionally, “the long-term labor of constructing an ethnic identity under a stigmatizing racial structure and the accumulation of ‘othering’ experiences over the life course might take a toll on the health of the second and later generations” (Viruell-Fuentes, 2007). This burden of over-exposure to ‘othering’ intersects with allostatic load and the weathering hypothesis, which will be addressed in Module 2.

There is a solution proposed by Horevitz & Organista, 2013, “utilizing qualitative methodologies to gain an emic perspective of the acculturative experience; accounting for covariates in statistical models that may have an additive or multiplicative relationship with acculturation (e.g., SES, stigma and discrimination, residence in an ethnic enclave, or social capital); and longitudinal study designs to better understand causal pathways between acculturative factors, including social mobility, and health outcomes over time.”

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3 Assimilation Pathways

- Straight-line assimilation
  - Simultaneous acculturation
  - Structural incorporation
  - Mainstream
- Downward assimilation
  - Barriers to economic mobility but rapid acculturation
- Selective acculturation
  - AKA Biculturalism
  - Delay acculturation through ties to ethnic communities
  - While investing in their children's educational attainments and upward socioeconomic mobility

Historically, the "achievement-oriented nature of immigrants to the US has been dismissed because of the prevailing assumptions that immigrant cultures are inferior to mainstream US culture and that assimilation is the only pathway to success for immigrants and their children" (Buriel, page 38).

To emulate is seen as a marker of successful adaptation. So much so, that the term "pressure cooker" assimilation was coined to describe the struggle to adapt by Gordon (1964). We must recognize that adaptation is not always linear, instead it is complex and can follow different pathways depending on context.

The information below comes directly from Horevitz & Organista (2013):

According to Portes and Zhou (1993), there are three main pathways of assimilation:

1. "Traditional upward assimilation into the White middleclass segment of society."
2. "Downward assimilation into the "underclass" segment (especially impoverished low SES racial and ethnic minority groups)."
3. "Intermediate path towards biculturalism, in which immigrants may achieve economic advancement, while still preserving their cultural heritage."
    a) "Thus segmented assimilation theory would attribute behavior changes,

such increased alcohol and substance use or poor diet, to a combination of individual markers of acculturative stress and downward assimilation into impoverished communities where, for example, fast food is cheap, ubiquitous, and too often beats out healthier foods (Finch, Lim, Perez, & Do, 2007; Portes & Zhou, 1993)."

b) "Portes & Zhou (1993) document that Mexican immigrants do not generally assimilate as far downward as the so-called underclass. While some Mexican American subgroups do appear to assimilate to the underclass, more information is needed regarding which structural and individual factors promote or prevent such movement."

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Portes, A., & Zhou, M. (1993). The new second generation: Segmented assimilation and its variants. *Annals of the American Academy of Political and Social Science*, *530*, 74-99.

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Buriel, Raymond. (2012). Chapter 2: "Historical origins of the immigrant paradox for Mexican American students: the cultural integration hypothesis:. In García Coll, C. T. (ED)l. *The immigrant paradox in children and adolescents : is becoming American a developmental risk?* (1st ed.). Washington, D.C.: American Psychological Association.

Photo credit: Diego Huerta

Solution: Promoting Biculturalism

- Entre Dos Mundos: Training program: Designed for families new to the acculturation process
- When the culture of origin and host-cultural systems are furthest apart and seem incompatible
  - Multi-family group intervention
  - Retention and reinforcement of immigrant Mexican culture
    - While simultaneously acculturating to the positive aspects of American culture
  - The resulting bicultural skills represent resilience
  - Becoming bicultural is a sign of resourcefulness and self-efficacy that should be nurtured and celebrated

The Entre Dos Mundos (Between Two Worlds) was an intervention created by Paul Smokowski, PhD- a social worker at UNC-Chapel Hill. The intervention is designed to "prevent the development of aggression, parent-adolescent conflict, and mental health problems in Latinx adolescents by helping participants cope with acculturation stress and by promoting family adaptability through bicultural coping skills." The goal is to help Latinx families adjust to life in the US and avoid the stress and problems associated with assimilation.

"The healthiest goal for immigrant adolescents and their families, and arguably for society as a whole in the US, is to become bicultural. Biculturalism in comparison to assimilation, separation/enculturation, or cultural marginality, provides a number of psychological, social, academic, and familial advantages that are noteworthy. The development of bicultural identity integration can be a long and strenuous process, but the resulting bicultural skills represent resilience in the face of acculturation stress and risk factors. Consequently, the process of becoming bicultural is a sign of personal, familial, and national resourcefulness that should be nurtured and celebrated" (Smokowski, 2011, p. 215-216).

"Bidirectional acculturation involves retention and reinforcement of immigrant

Mexican culture while simultaneously acculturating to the positive aspects of American culture. The result is a bicultural adaptation strategy that enables individuals to meet the positive expectations of American culture without sacrificing the empowering aspects of Mexican culture." As a practitioner one most identify, validate, foster, and help negotiate how the patient may become sustainably bicultural (Buriel, 2012, p.55).

A typical philosophy of social work is to meet people were they are at in that specific moment in time. Along those lines in anthropology, we believe in withholding judgement and becoming a novice in order to understand the interconnectivity and intricacies of human existence. All in all, this is an empowerment framework that focuses on allowing people to be the authors of their own stories, to voice them, and be validated for their experiences. After all, they are the true experts of their lives. So let's foster skills that promote self-efficacy and help them help themselves.

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Smokowski, P. R. (2011). *Becoming bicultural : risk, resilience, and Latino youth*. New York: New York University Press.

Buriel, Raymond. (2012). Chapter 2: "Historical origins of the immigrant paradox for Mexican American students: the cultural integration hypothesis:. In García Coll, C. T. (ED)l. *The immigrant paradox in children and adolescents : is becoming American a developmental risk?* (1st ed.). Washington, D.C.: American Psychological Association.

Photo credit: Cornelio Campos "Frontera"

TABLE 7.1
Entre Dos Mundos Curriculum Themes

Session	Theme Questions
Week 1	How are we as a family changing as we adapt to life in the United States? How do we as a family balance demands from two different cultures (our culture-of-origin and the U.S. host culture)?
Week 2	What worries do adolescents have for their parents? What worries do parents have for their adolescents? How can we help each other decrease some of these worries? How can we comfort one another?
Week 3	When cultural conflict arises, how can we remain united with each other as a family when we have different perspectives?
Week 4	How can we handle discrimination at school and at work? In what ways can family members support each other during or after these experiences?
Week 5	In what ways do adolescents participate in school? In what ways do adolescents wish to participate in school? (Same two questions posed to parents.)
Week 6	How can we strengthen our relationships with non-Latino Americans (peers, teachers, co-workers) outside of our families?
Week 7	What does our future look like in 10 years? (Developing bicultural identities)
Week 8	Review, integration, evaluation, and closure (graduation ceremony and fiesta!)

Above is the curriculum for the Entre Dos Mundos Intervention. Every week there is a cluster of questions that can be adapted to use in a inter-professional consultation and treatment plan.

Reference:
Smokowski, P. R. (2011). *Becoming bicultural : risk, resilience, and Latino youth*. New York: New York University Press.

Abuelita's wisdom: Come bien, camina y no te preocupes

- Selective biculturalism exists when an individual from one cultural group interacts regularly with another cultural group, then selectively takes on, maintains, or abandons certain cultural traits (i.e., health beliefs) from each group (Laganá, 1996).
  - To maintain or reject culturally dictated practices and beliefs to fit their needs.
- Need for skill building intervention to reduce stress
  - Not currently part of routine prenatal care
  - Capitalize on already existing coping strategies (prayer) and recommend new (mindfulness)

From Lagana's ethnographic study in Watsonville, California:

The dictates of traditional practices during pregnancy were simple: "Eat right (come bien), walk (camina), and don't worry (no se preocupe)."

1. "Eat right (Come Bien). The diet (la dieta), a low fat, high protein, and nutritious natural diet, was the most commonly cited determinant of healthy birth outcome. Women distrusted processed or canned foods and were encouraged by grandmothers and husbands to eat regular homemade meals, which usually included boiled beans (frijoles de olla), corn tortillas, rice, and fresh produce. More acculturated women reported that eating well was difficult if they were working. The use of harmful substances and alcohol during pregnancy was sharply criticized and, as noted earlier, led to loss of respect and social power."

2. "Walk (Camina). From an Anglo cultural orientation, the women interviewed reported an association between exercise and body image. However, exercise from the Mexican perspective was seen as important for general well being. One traditional woman reported that failure to maintain physical activity could result in a folk condition she called 'se pega,' in which the fetus sticks to the inside of the uterus,

making delivery difficult. Grandmothers encouraged daily walks. During pregnancy, women usually gave up more rigorous exercise (i.e., aerobics or running) at the encouragement of their mothers, even though their prenatal care providers approved these forms of exercise. Certain physical activities such as lifting, bending, or extended time standing were seen as harmful."

3. "Pregnant women were protected from upsetting news and family members who upset them were sharply criticized. Although the Mexican concept 'preocuparse' or the action of worrying, is similar to the Anglo concept "stress," there seems to be a critical difference based in degree of control. 'No se preocupe' uses the verb to indicate an internalized decision not to respond to stressful outside influences. The concept of stress, a noun, is an externalized object that bombards the woman frequently and from multiple sources. 'No se preocupe' places the responsibility back on the pregnant woman in the form of an expected health behavior of stress reduction. Family social support facilitates stress reduction. The herb chamomile, recognized for its calming effects, was frequently administered to women for stress. Advice to not worry led many of the women interviewed to simplify their lives during pregnancy. This included leaving jobs and moving together with supportive family members."

In Watsonville, traditional pregnancy health behaviors included active stress management through the cultural dictate "no se preocupe."

Findings from this Mother Study suggest that the promotion of strong social support networks and active stress reduction during pregnancy are important to healthy birth outcomes. For example, prayer is a traditional and culturally relevant strategy that can be utilized to healthfully cope with life's stressors. Further, mindfulness is an evidence-based strategy that can be used to self-regulate and build distress tolerance skills.

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Photo credit: Diego Huerta

Maintenance & Sustainability in Practice

- Informal systems of care can complement formal systems
  - By expanding the roles of individuals who participate to some degree in both systems.
    - Community health workers (promotoras), lay midwives (parteras), and caregivers who provide support during labor and the postpartum period (doulas).

1) Focus on outreach

2) Deputize cultural gatekeepers to validate beliefs and practices

3) Empower as leaders→ sustainability

4) Personalimo in action

- Interventions must be
  - active-directive, problem-focused, and skill-enhancing

Given what we know about the power of socio-cultural capital, a multi-tiered intervention is necessary. In a study conducted among low-income agricultural community of women of Mexican descent in California, Harley and Eskenazi found that "higher social support was associated with better quality of diet, increased likelihood of using prenatal vitamins, and decreased likelihood of smoking during pregnancy. High social support also appeared to prevent the negative impact of life in the US on diet quality." Thus, in the case of diet quality and behavior, increased social support appears to prevent some of the negative pregnancy behaviors that accompany time in the US among women of Mexican descent. In order to maintain and sustain these outcomes, we must integrate the informal systems of care that support women with the formal systems of care with which they interface.

From McGlade et al., (2004):

"Informal systems of care can complement formal systems by expanding the roles of individuals who participate to some degree in both systems. These individuals include community health workers (promotoras), lay midwives (parteras), and caregivers who provide support during labor and the postpartum period (doulas). These lay practitioners, who are typically members of the communities in which they work and

who have had formal or informal training in maternal and child health, can serve several integrating functions."

1. "Provide outreach to ensure pregnant women are aware of and access formal prenatal care services."
2. "Deputize members of the community, particularly older immigrant women, whose experience and knowledge are integral to maintaining the benefits that appear to be lost with acculturation. Deputizing these women validates their beliefs and practices, which may be looked down upon by more acculturated women, and it empowers the women as community leaders, which may help preserve within the community the traditional Latinx cultural context that appears to confer positive health effects."
3. "Lay practitioners can organize community members to provide the type of social support system for pregnant mothers that exists in most areas of Latin America, but often disintegrates in the United States."
4. "The personal contact provided by community-based lay practitioners serves some of the functions and roles of the informal system of care."

The best practice here concerns interventions that are "active-directive, problem-focused, and skill-enhancing forms of treatment" (Gallagher-Thompson et al, 2003). This combination of family-centered, bilingual as well as bicultural care creates a safe space, fosters trust, and promotes compliance and follow-up.

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Photo credit: Diego Huerta

Medical Anthropology & Ethnography

- Health issues and how they intersect with
  - Environment, ecology, gender, sexuality, race/ethnicity, nationality, and class subjectivities.
- Tool: When taking medical history employ ethnographic methods
  - Observe and listen for context
  - To understand the 'how' and the 'why' not only the 'what' and 'when'
  - Reveals elusive trends
  - Code for descriptive labels
  - Sort for patterns
  - Identify outliers

In order to understand the variables influencing these positive health outcomes, we must unpack the context. One strategy to understand human behavior and its intersection with health is Medical Anthropology.

Medical Anthropology is concerned with how we collectively understand health, illness, healing, living, and dying…all of which are embedded in the meaning of what society values about how things are meant to be and how to right the wrongs. Even the body is shaped by cultural meanings of what it means to be healthy and beautiful. Further, culture influences etiological beliefs of what causes illness/affliction. At the same time, culture affects how the treatment and therapy will match up conceptually with an understanding of where the illness comes from.

Ethnography is a research methodology tool used by anthropologists that is both a process and a product. By accessing beliefs and a patient's modus operandi, the health care provider can view the person in context. By understanding the patient's views on the experience of illness, the provider may then contextualize their approach in a more nuanced way (Savage, 2000).

Ethnographies are culturally-based and depend on observation and interview. This

research method is useful especially when there is no compliance or lack of follow-up. This technique is employed in order to understand the patient and where/how they are embedded in a system that enables or prohibits certain behaviors. Additionally, ethnographic research aids the health care provider in understanding how patients make decisions (Goodson & Vassar, 2011).

The best tool to employ when taking the medical history of a patient is to contextualize ethnographic methodologies. First, observe and listen in order to bridge the 'how' and the 'why' with the 'what' and 'when.' This will reveal elusive trends that lab results do not always provide. Then, look for systemic patterns in order to get a holistic representation of the patient's past, current, and future status.

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The Evolution of Competence

Cultural Competency

↓

Cultural Sensitivity

↓

Cultural Humility

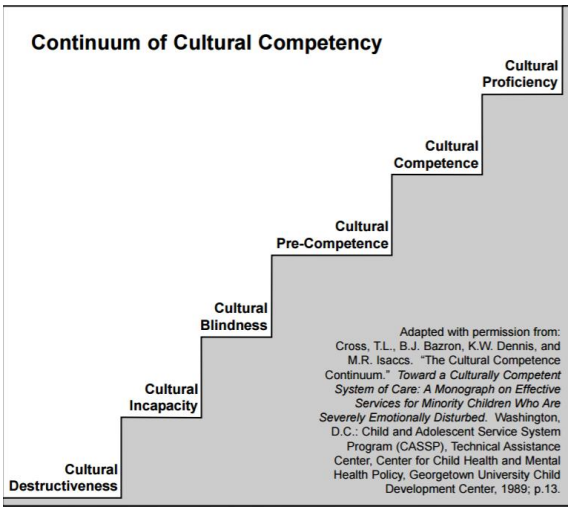
↓

Structural Competency

Please remember that: generalizations are a starting point, not an endpoint. The goal with each of these competencies is to achieve an equilibrium between the provider and patient relationship. Indeed, the provider is the expert on medicine whereas the patient is the expert on self.

Cultural Competence

- "Cultural competence is, the set of behaviors, attitudes and policies that come together in an institution, agency, or among a group of individuals, that allows them to work effectively in cross-cultural situations" (National Alliance for Hispanic Health, 2011).



"Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations…. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (National Alliance for Hispanic Health, 2011).

Above all, it is important to remember that when dealing with translation and interpretations: it must be cultural, not mechanical.

Yet this competency is not enough because it is just one part of the story. In order to fully understand the humanity of a patient, providers need to be whole-hearted and whole-minded.

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Cultural Sensitivity

"What we don't need in the midst of struggle is shame for being human." Brené Brown

Table 2 Cultural sensitivity and awareness checklist

Focus	Instructions
1. Communication method	Identify the patient's preferred method of communication. Make necessary arrangements if translators are needed.
2. Language barriers	Identify potential language barriers (verbal and non-verbal). List possible compensations.
3. Cultural identification	Identify the patient's culture. Contact your organisation's culturally specific support team (CSST) for assistance.
4. Comprehension	Double-check: Does the patient and/or family comprehend the situation at hand?
5. Beliefs	Identify religious/spiritual beliefs. Make appropriate support contacts.
6. Trust	Double-check: Does the patient and/or family appear to trust the caregivers? Remember to watch for both verbal and non-verbal cues. If not, seek advice from the CSST.
7. Recovery	Double-check: Does the patient and/or family have misconceptions or unrealistic views about the caregivers, treatment, or recovery process? Make necessary adjustments.
8. Diet	Address culture-specific dietary considerations.
9. Assessments	Conduct assessments with cultural sensitivity in mind. Watch for inaccuracies.
10. Health care provider bias	Always remember, we all have biases and prejudices. Examine and recognise yours.

Remember that progress is directly dependent on the degree of trust. Therefore, respect for the patient's values, beliefs, and expectations is of utmost importance. A non-judgmental attitude is a pre-requisite.

Being culturally sensitive is ethically important because it gives you the skills needed to adapt care to be congruent with the patient's ethos.

A multi-disciplinary team who can serve as liaisons and cultural brokers is helpful because they can link patients to available resources in the community that are relevant to the patient's needs and experiences.

Reference:

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Cultural Humility

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your problem does inside your body?
4. How severe is your problem? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your illness has caused you?
8. What do you fear most about your illness/treatment?

The cultural humility approach is focused on the power of connection through being humble. “Connection is the energy that is created between people when they feel seen, heard, and valued.” Brené Brown

Cultural humility is a necessary, yet insufficient condition of care. Health care providers should not settle for cultural humility as being enough. For example, learning how to accurately pronounce a name is necessary, yet it is not enough to build rapport.

The questions above are useful to further understand a person and their perspective. The questions were created by Dr. Kleinman, a physician as well as an anthropologist from Harvard who focuses on how cultural beliefs impact an individual’s understanding of health and illness. This approach offers a strategy to understand the patient’s “illness narrative.”

“This process prevents medical providers from developing the hubris of mastery, which is not only counterproductive, but insensitive. Instead, clinicians develop the humility to recognize the complexity of structural constraints that patients and doctors operate within” (Tervalon & Murray-Garcia, 1998).

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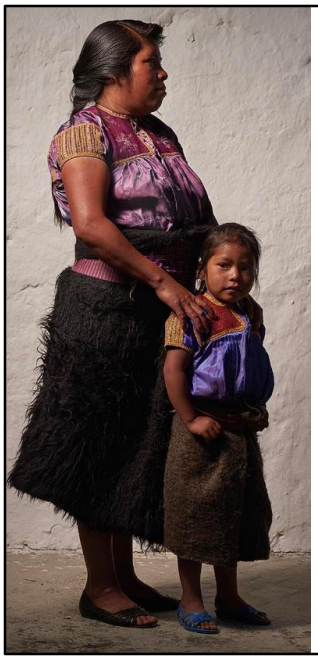

However, culture is not enough…

- Cultural explanations mask the effects of social inequalities on immigrant health outcomes
- Employing acculturation as the central concept in the examination of immigrant health outcomes in the US ignores
  - The socio-historical contexts of migration
  - The racialization of contemporary immigrants
  - The role these factors play in the differential social integration of immigrants
- Explanations/interventions that "place the onus of culture on the individual are likely to lead to individual-centered interventions at the expense of addressing the structural contexts that reproduce social and economic inequities" (Virruel, 2007).
  - Risk of
    - Essentializing
    - Homogenizing
    - Perpetuating stereotypes
    - Promoting victim-blaming behaviors

Culture and cultural explanations are not enough and can backfire because they obscure the impact of structural factors on immigrant health disparities. Therefore there needs to be a shift from individual culture-based frameworks to perspectives that consider the role of structural factors in producing health inequalities among immigrants. When we focus on frameworks based on individualized cultural responses to structural factors, then we "obscure the role that institutional actors and policies play in (re)producing poverty, racial discrimination, and nativist reactions to immigrants, all of which likely influence the health of immigrants above and beyond the influence of such factors on cultural traits" (Virruel-Fuentes 2012).

Indeed, "persistent use of individual or culture driven models in public health ignores the effect of residence in low-resource communities, low SEP [socioeconomic position], the social construction of marked cultural identities, and institutional patterns of unequal treatment, all of which contribute to health disparities" (Zambrana and Carter-Pokras, 2010, p. 21).

The use of static definitions of culture in public health research risks essentializing (to reduce to its simplest form) and homogenizing (to standardize) entire ethnic and/or immigrant groups and perpetuating racial/ethnic stereotypes (Hunt et al., 2004),

thereby “inadvertently promoting victim-blaming explanations” (Viruell-Fuentes, 2007, 2011, p. 38).

References:

Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science and Medicine*. 2012;75:2099-2106.

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Photo credit: Diego Huerta

Structural Competency

Focus on forces that influence health outcomes at levels above individual interactions

Tenets:

1. Recognizing the structures that shape clinical interactions
2. Developing an extra-clinical language of structure
3. Rearticulating “cultural” formulations in structural terms
4. Observing and imagining structural interventions
5. Developing structural humility

Generally, medical providers are trained to listen to individualized stories, not structural ones. This philosophy leads to upstream decisions with downstream consequences. Let’s take into consideration some of the structures that may potentially impact the patient in terms of stigma and or conflict: insurance coverage, pharmaco-economics, pharmacy policies and all of the sequelae of a host of financial, legal, governmental, and ultimately ethical decisions.

This latest iteration is important because if not practiced, then culture may be glorified, scape-goated, or demonized. This then makes culture an excuse that makes it untouchable or unfixable by interventions. Therefore, a career-long engagement with learning and acting in micro and macro level negotiations about structural issues is necessary. Medical providers should remember their positionality and their dualistic nature of speaker and listener, leader and collaborator.

Civil Rights activist Stokely Carmichael believed that forms of racial bias are embedded not in actions or belief of individuals, but in the functions of social structures and institutions. Therefore, as medical providers, we must understand how diseases or impoverished economic infrastructures can lead to diseases or impoverished or imbalanced bodies or minds.

For example, let's look at a problem like obesity which might have once been labeled "noncompliant" with medical advice through the structural competency lens. If we do so, then we may reframe the problem in terms of failing infrastructural systems such as lack of access to nutritious, affordable and healthy foods and not an individual moral failure.

Metzl has five tenets that broaden clinicians' story listening skills from the individual to the structural and beyond:

1. Recognizing the structures that shape clinical interactions
    a) Clinicians should consider how the amount of time spent during a visit affects the content of conversation, rapport, and likelihood of treatment adherence.
    b) Clinicians should understand that experienced symptoms are sequelae of a host of financial, policy-related, legal, governmental, and ethical decisions that function as root causes of most diseases and conditions.
2. Developing an extra-clinical language of structure
    a) Shift to an integrative approach of disciplinary and interdisciplinary understanding and conceptualization (use medical anthropology, medical sociology, history, health economics) of social structure and social forces.
    b) Understand how health and illness are produced and even maintained due to structural violence and infrastructure failure (Farmer, 2001). This way, clinicians can assess and intervene with a contextual understanding of how social structures interact with biologies.
3. Rearticulating "cultural" formulations in structural terms
    a) Clinicians should acknowledge the limitations of the language and logic of the term 'cultural' to describe consequences and health outcomes. Especially, when in reality consequences and outcomes are due to the biased systems that become the structural determinants of health. If not, culture becomes an untouchable and unfixable construct that is either glorified or demonized.
    b) Medical education should make the implicit, explicit. By virtue of developing a new way of expression through intercultural communication, clinicians and communities can shift the "diagnostic focus from the 'culture' of the individual to the cultures of privilege and oppression that structures, like human constructions, represent."
4. Observing and imagining structural interventions
    a) First, employ historical observation in order not to reinvent the wheel: use oral histories, archival analyses, and literature searches to analyze previous attempts to address social justice issues that impact the tri-dimensionality of health (mind, body, spirit). For example, use clinical ethnographies of community based interventions. An inspiring best practice can be traced back

to activist-physician Jack Grieger who wrote prescriptions for quality food to be filled at grocery stores. Along with his prescription, there were instructions to send the bill to his health center. Knowing history can help prevent future mistakes and ensure sustainability.

b) Overall this is a call-to-action for a patient-centered approach (mico) or a community-centered approach (macro) that complements the community participatory research movement already in place.

5. Developing structural humility

a) Ability to recognize limitations of structural competency; yet, still commit in a career-long way to learn and act in micro and macro level negotiations about structural issues that impact health outcomes.

b) Practitioners should be mindful of humility, a concept developed by Philosopher Emmanuel Levinas "the Other always lies beyond the comprehension of self." This way, practitioners can understand their dualistic roles as "speakers and listeners, leaders and collaborators, experts and benighted."

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Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133. doi:10.1016/j.socscimed.2013.06.032

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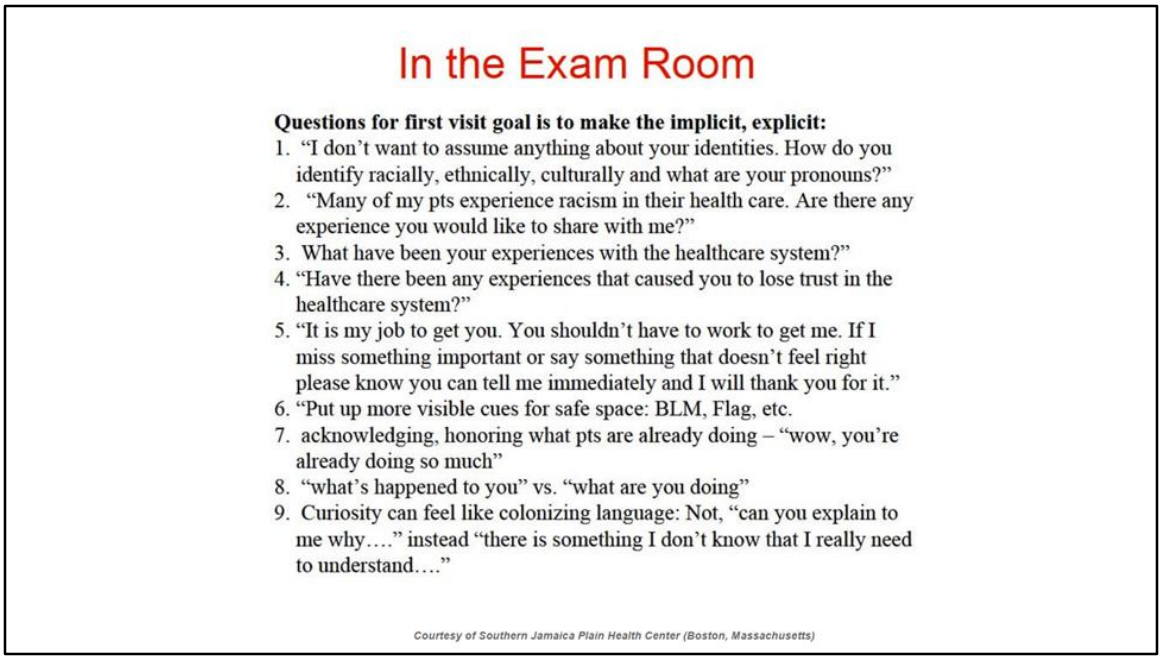
Photo credit: Diego Huerta



Capacity building exercise: Reflect on "How could you incorporate these strategies into your specific practice area? Which questions do you think are more relevant, effective? How so?"

Above are some question that you can use at the start of clinical encounters. Remember that first and foremost you should give an opportunity for the patient to express themselves by asking: "Are there any experiences you would like to share with me before we start?" Specifically, the practitioner should actively listen for major life changes and stressors. Knowing you have limited time, focus on identifying the problem(s) and refer out to a social worker or case manager.

Remember that asking "why" may sound accusatory so change the framing of the question by using "how come," "how so," or "tell me more." Also, use open-ended questions.

Ultimately, the goal is to make care more person-centered by using open-ended questions to open up dialogue. Provider must convey humility through interest and willingness to learn from and with the patient.

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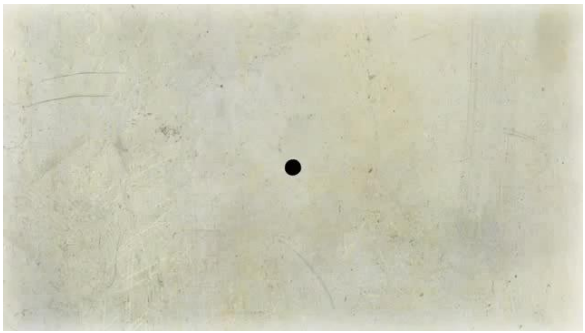
Patient-Centered Care

- Empathy: view experience through patient's eyes in order to become more responsive to needs
- Idea of "Nothing about me, without me."
- Shared decision-making
  - Clinician offers options and describes risks and benefits
  - Patient expresses preferences and values
- Become more effective coaches/partners
  - Ask, "What matters to you?" as well as "What is the matter?"



"Nothing about me, without me" is the quote at the beginning is from the Salzburg statement endorsing shared decision making, authored by representatives from 18 countries. The video above is Brené Brown's distinction between empathy and sympathy, both of which are essential in patient-centered care.

To continue on the insights of best practices, let's look at Brené Brown's definitions and strategies:

1. "If you are going to assume, assume the best in people- they are doing the best they can."
2. "Compassion is a deeply held belief that we are intractably connected to each other by something rooted in love and goodness"
    1. "Compassion is not an entity "we" show toward the "other."….We need to lose the dichotomy. It is not something I have and give to you. It manifests in the relationship between beings…. If we are wholeheartedly engaged in each moment, responding to what is front of us, not judging or labeling ourselves or others, then I believe that compassion cannot fatigue" (Marr, 2009) .
3. "Empathy is the skills-set to bring compassion alive. How to communicate that deep love for people in a way that people know that they are not alone. In

> actuality, you are not feeling for someone. It is feeling with them. Touching the place in me that knows where you have been so that you can look at someone and say “me too.” Empathy is sustaining and infinite, you can thread the empathy waters forever without burn out as long as you have done your work with boundaries (what is ok and what is not ok). In other words, boundaries are respect.”

The literature extolls the golden standard of practice of patient-centered communication by revealing an association between physician communication behaviors and positive patient outcomes such as “patient recall, patient understanding, and patient adherence therapy” (King & Hoppe, 2013). All in all, the idea of shared decision-making as the most valued asset in a healing interaction is not new. The Picker Institute coined the term “patient-centered care” in 1988. This term demands a systematic shift from a hyper-focus on diseases to the individual (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993). So much so, that a call-to-action is made on clinicians to “relinquish their role as the single, paternalistic authority and train to become more effective coaches or partners - learning to ask: what matters to you?" (Barry & Edgeman-Levitan, 2015).

The concept was made official by the Institute of Medicine report on Crossing the Quality Chasm. The report extolled patient centered care as one of the fundamental approaches to improving quality of health care in the US. The report defined patient-centered care as “care that is respectful of and responsive to individual patient preferences, needs, and values” and that ensures “that patient values guide all clinical decisions.”

According to the latest Cochrane review of 86 trials published through 2009, “the use of patient decision aids for a range of preference-sensitive decisions led to increased knowledge, more accurate risk perceptions, a greater number of decisions consistent with patients’ values, a reduced level of internal decisional conflict for patients, and fewer patients remaining passive or undecided” (Stacey et al, 2011).

“In shared decision making, both parties share information: the clinician offers options and describes their risks and benefits, and the patient expresses his or her preferences and values. Each participant is thus armed with a better understanding of the relevant factors and shares responsibility in the decision about how to proceed.” (Charles et al. 1997).

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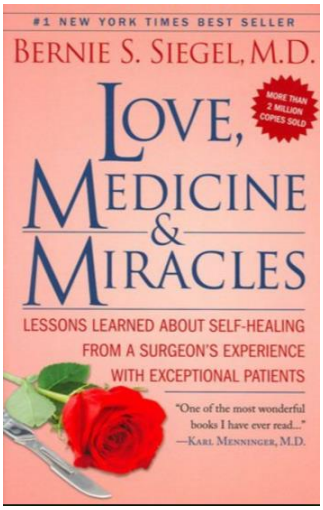
Love, Medicine, and Miracles

- Success-oriented relationship
- Look at your role as a privileged listener
- With consent, you can help by touching, praying, or simply sharing on an emotional level
- Coldness doesn't save anyone from pain
- Invite patient to participate in recovery
- Give a prescription of hope, self-love, self-care
- Live the life you are prescribing: don't be hypocritical
- Ensure treatment addresses the patient's entire life



Love, Medicine, and Miracles is a book by Bernie Siegel, M.D. that exemplifies patient-centered care.

Here are some of the insights:

1. "The healing partnership should consider hope, compassion, and acceptance in order to be a success-oriented relationship. Your role as a privileged listener is to allow people to tell you everything in order to make an accurate diagnosis and prescribe a holistic course of treatment."
    1. "When a doctor can instill some measure of hope, the healing process sometimes starts even before treatment begins." page 43
    2. "Shared responsibility increases cooperation and reduces resentments that often lead to malpractice suits" pg 52
2. Siegel claims that false hope and detached concern should be omitted from practice. On that note, never tell a patient "there is nothing more I can do for you. There is always more to do. For example, sitting with the patient, holding their hand, praying with them, talking with them, giving them peace. Resist giving a prognosis that talks about deadlines. First, we are not that powerful to know. Second, the relationship suffers once there is a death date prophesized.

Therefore, find a way in which the truth can be delivered with hope, given that no one can be certain of the future."

    1. Encourage patients to have faith, and also to help God make miracles. Siegel says that he "encourages patients to believe in God but not to expect Him to do all the work" Page 178
    2. Avoid the pitfalls of fatalism. He suggests that "patients think of illness not as God's will but as deviation from God's will." Page 179

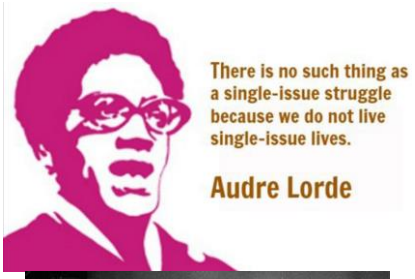
1. Practitioners should model behavior. "We must live the sermon, not just deliver it." page 59
    1. Remember that prescriptions function as permission slips. How often have you heard the excuse: "well, my doctor said….{fill in the blank}." Use them to prescribe self-love and self-care!
2. "A doctor who acts out of love doesn't burn out. He or she may get tired physically, but nor emotionally." page 61

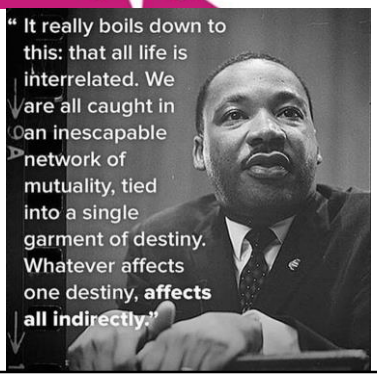
Reference:

Siegel, B. S. (1988). *Love, medicine, & miracles : lessons learned about self-healing from a surgeon's experience with exceptional patients* (1st Perennial Library.). New York: Harper & Row.

Module 2: Intersectionality

- Social Determinants of Health
- Migration and Mental Health
- Risk and Resilience
- Spirituality/Religiosity
- Traditional Healing Systems
- Cuarentena
- Nutrition





Intersectionality: An interpretive and analytical theoretical framework for understanding how socially constructed identities (such as race, gender, sexual orientation, SES, and disability) interconnect at the micro level of individual experience to reflect systems at the macro-structural level. The multiple identities we each embody as individuals and how each of those identities impact our lived experiences as we navigate systems of privilege and oppression concerns the study and application of intersectionality (Bowleg, 2012).

"Acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of health disparities for populations from multiple historically oppressed groups. The other critical step is recognizing how systems of privilege and oppression result in multiple social inequalities (e.g. racism, heterosexism, sexism, classism) that intersect at the macro social-structural level to maintain health disparities" (Bowleg, 2012).

As health practitioners, we have a two-fold responsibility: to build power within communities that are marginalized, and also build bridges between all communities.

For example, we can even see intersectionality in nature. The pando tree,--which

means “I spread” in Latin—is a single living organism that has one massive underground root system. It is the heaviest known organism and also one of the oldest. It is located in Utah; it encompasses 43 hectares and weighs 6,000 metric tons. This is a perfect example of how we are all interconnected. Especially, this concept can be applied when we zoom in to how intersectionality affects women’s sexual and reproductive health throughout their life course.

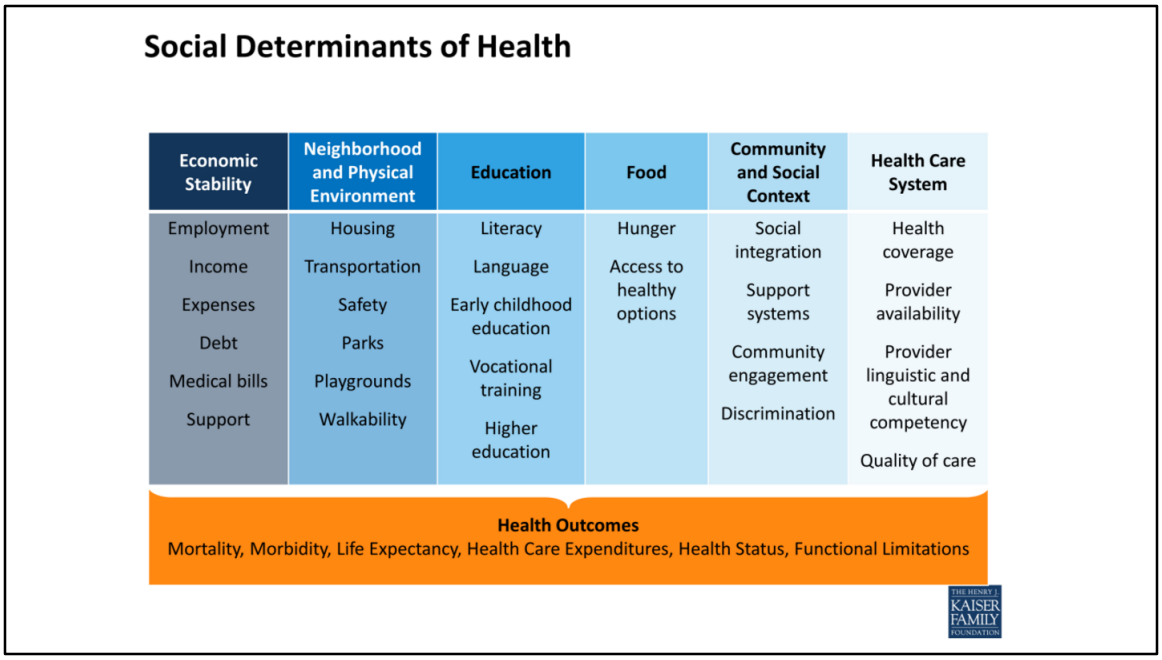
From Virruel, 2007 article:
“Contrary to articulating gender, race, and class as distinct social categories, intersectionality postulates that these systems of oppression are mutually constituted and work together to produce inequality (Cole, 2009; Collins, 1990; Crenshaw, 1991; Schulz & Mullings, 2006). As such, analyses that focus on gender, race, or class independently are insufficient because these social positions are experienced simultaneously. Whereas intersectionality has had an impact on both feminist theory and Critical Race Theory, its integration into the health inequalities literature has been limited (for some exceptions, see Ford & Airhihenbuwa, 2010; Kelly, 2009; Rosenthal & Lobel, 2011; and Schulz & Mullings, 2006). This limitation is most noticeable in immigrant health research where the acculturation paradigm dominates and examinations of how immigrant health trajectories are shaped simultaneously by race, class, and gender-based systems of hierarchy are, by and large, absent.”

“In the public health literature, immigration-related variables such as nativity, generational status, language use, length of time in the United States, citizenship status, and age at migration are often interpreted as proxies for acculturation. Applying intersectionality theory to the study of immigrant health would thus require fuller theorizing about the meaning of these markers under specific contexts, and about how these meanings are mutually influenced by race, class, gender and other social hierarchies… Amidst increasing anti-immigrant environments, a focus on the structural factors that influence the lives of immigrants and those of subsequent generations is necessary to better develop multilevel interventions that promote the successful, healthy integration of immigrants and their children into the country.”

References:

Viruell-Fuentes EA. Beyond acculturation: Immigration, discrimination, and health research among Mexicans in the United States. *Social Science & Medicine*. 2007;65:1524-1535.

Bowleg L. The Problem With the Phrase Women and Minorities: Intersectionality-an Important Theoretical Framework for Public Health. American Journal of Public Health. 2012;102:1267-1273.



Health equity can be understood as all people having the opportunity to attain their full health potential without the disadvantages caused by social determinants (Health Resources and Services Administration). The WHO defines the social determinants of health as the environment in which people are born, grow, play, work, co-exist, and age. Therefore, if the systems that sustain those environments are not ready, willing, nor able to meet the demand, then the population suffers.

Based on a meta-analysis of nearly 50 studies, researchers found that social factors, including education, racial segregation, social supports, and poverty accounted for over a third of total deaths in the United States in a year (Galea, 2011). However, it is important to note that social determinants of health go beyond the individual. In other words, social-structural factors beyond the individual have power over individual health. For example, "you can predict the life expectancy of a child by the zip code in which they grow up," which is an infrastructure failure, not a moral nor personal one (Bostic & Lavizzo-Mourey, 2011).

The Robert Wood Johnson Foundation released a report on the best practices regarding how health practitioners should address social determinants of health. The following statements/proxies work because they focus on a solution instead of the

problem. These statements implicitly acknowledge the notion of personal responsibility and foster proactivity.

Use proxies to describe Social Determinants through a Prevention Lens:

1. "Health starts-long before illness-in our homes, schools and jobs."
2. "Your neighborhood or job shouldn't be hazardous to your health."
3. "Your opportunity for health starts long before you need medical care."
4. "Health begins where we live, learn, work, and play."
5. "The opportunity for healthy begins in our families, neighborhoods, schools and jobs."

The report lists seven lessons. Here are a couple of the most relevant ones.

Lesson 2:
"Priming audiences about the connection with messages they already believe makes the concept more credible. Messages that incorporate the importance of available quality health care with the need to address the social factors that affect health were more convincing than those that did not discuss medical care at all. When messages are presented in colloquial, values-driven, emotionally compelling language, they are more effective. Academic language, including "social determinants," did not resonate with audiences the way language like 'health starts in our homes, schools and communities' did."

Lesson 5:
"Incorporate the role of personal responsibility. The importance of all Americans having equal opportunity to make choices that lead to good health resonated with participants across the "political spectrum. Incorporating this point made respondents more receptive to the idea that society also has a role to play in ensuring that healthy choices are universally available.

References:

Galea et al., "Estimated Deaths Attributable to Social Factors in the United States" *American Journal of Public Health* 101, no. 8 (August 2011):1456–1465, doi:10.2105/AJPH.2010.300086.

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Heiman, H. & Artiga, S. (2015) Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.
Available at: http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Health Resources & Services Administration. Office of Health Equity. Available at http://www.hrsa.gov/about/organization/bureaus/ohe/.

Social Determinants of Health. (2016). World Health Organization. Available at http://www.who.int/social_determinants/en/

Robert Wood Johnson Foundation. A new way to talk about social determinants of health. Vulnerable Population Portfolio. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023

Inter-Professional Collaboration and Referrals

- Health related social circumstances screening is problematic
  - Most of the remedies for social determinants lie beyond the health sector
- Screening tools should always be interpreted in the context of what is known about the patient and family.
  - Promote protective factors and self-efficacy
  - Screen everybody
    - Food insecurity, unemployment, and interpersonal violence

The previous slide emphasized the importance of prevention. Given that there are forces that influence our lives that are outside of our control, we must address the social determinants of health in the micro and macro sense. In order to do so effectively we need coordination of services and cross-sector collaboration in order to avoid reinventing the wheel and burn-out. We can bridge this gap with inter-professional collaboration and referrals. Remember that "screening for any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and, arguably, unethical" (Perrin, 1998).

From the Garg (2016) article:

We must remember that "screening for patients' health-related social circumstances is fundamentally different from screening for traditional medical problems for which screening tools, diagnostic methods (e.g., laboratory testing, imaging), and interventions are accessed within the health services sector. In contrast, screening for social determinants can detect adverse exposures and conditions that typically require resources well beyond the scope of clinical care."

"Despite the potential benefits of identifying and addressing adverse social

determinants, there is the potential for unintended harm. Such screening could yield expectations that, if unfulfilled, could lead to frustration for patients and physicians alike. Furthermore, patients' perceptions of physicians as judgmental, presumptuous, or even callous could erode the patient-physician relationship."

Lastly it is imperative that providers address sensitive and taboo topics such as food insecurity, sexual activity, unemployment, housing, and interpersonal violence. The best way to ask about such topics is to be clear and concise. One may use open-ended questions. You can explicitly acknowledge that indeed the questions may seem invasive and indirectly relevant to the patient's health, but it is the standard protocol you follow with everyone who comes into your practice in order to improve quality of life.

References:

Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the Unintended Consequences of Screening for Social Determinants of Health. *JAMA*. 2016;316:813-814.

Perrin EC. Ethical questions about screening. *J Dev Behav Pediatr*. 1998;19(5):350-352.

Photo credit: Diego Huerta

What to do and what not to do…

- Implement Theory of “Acompañar”
- Do NOT limit screening practices based on apparent social status
- Social determinants screening should
  - Be patient- and family-centered and involve shared decision making
  - Be conducted within a comprehensive process and system that supports early detection, referral, and linkage to a wide array of community-based services
  - Acknowledge and build on the strengths of patients, families, and communities.
    - Remember that the presence of family-level protective factors as specific support in times of need, social connections, and resiliency correlates with positive long-term outcomes (Hughes, 2016).
  - 2-1-1: free and confidential helpline

Now, let’s look at the specifics of implementation of comprehensive and inclusive screening practices.

Brené Brown’s theory of accompaniment provides a solid foundation that helps us understand why and how to do screening. The theory is based on the liberation theology movement in Latin America, led by Archbishop Oscar Romero in El Salvador. The concept and call to action focuses on how the church should accompany its followers and work with them. For Brown, “Acompanar is the basic social process helping professionals use to develop, maintain and assess their relevancy in the helping process.” The concept of Acompañar suggests “elements of starting and staying with the client, honoring self-determination, use of self, and relationship as tool.” The partnership is based on walking alongside instead of leading or following the patient, all of which fosters trust and rapport. Practitioners must effectively share their knowledge and resources while honoring the fact that utilmately it is and will always be the patient’s journey. Acompañar is based on the concept of creating meaningful as well as relevant conditions in order to achieve “effective helping” partnerships with clients. Acompañar encourages the patient/ client to be an expert in their life, a cornerstone of social work theory and practice. Also, the theory “explains that helping professionals can be both ‘experts on the process’ and ‘novices

regarding individuals and communities'."

This dualistic role of being a student and teacher at the same time can be a challenge; but we, as practitioners, must overcome it in order to improve the quality of care we provide. The following recommendations of what to do and what not to do come from Grag et al, 2016**:**

What not to do:
"Clinicians should avoid recommending risk-stratification models that automatically refer patients who meet a specific threshold or severity of unmet material needs either directly to community services or via embedded support staff such as patient navigators without elicitation of patients' opinions, concerns, and priorities and shared decision making."

"Do not limit screening practices based on apparent social status: targeting families based on such characteristics only reinforces stereotypes and prejudicial presumptions as well as stigmatizes the screening process. If clinicians and office staff deem screening for social determinants to be feasible and desirable, then ALL patients in the practice should be considered for participation."

What to do:

"Screening for adverse social determinants should therefore be accompanied by identifying the opportunities, strengths, assets, and protective factors of patients and families. Awareness of assets and opportunities related to the built and social environment within communities is an additional resource for health promotion."

"Medical home support staff, such as community health workers, patient navigators, and case managers, may facilitate linkage with available community programs if desired by patients."

"Use centralized access (e.g., 2-1-1, which is a free and confidential US helpline and website that connects people to essential health and human services)."

References:

Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the Unintended Consequences of Screening for Social Determinants of Health. *JAMA*. 2016;316:813-814.

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Brown CB. *Acompañar: A grounded theory of developing, maintaining and assessing relevance in professional helping.* ProQuest Dissertations Publishing; 2002.

Photo credit: Diego Huerta

Immigration as a Social Determinant of Health

- Immigration involves a complex process of negotiation with protracted processes of negotiation with social, structural, political, and economic forces
  - Immigration influences all other social relationships and is a lived experience that directly affects health and well-being
    - Consider how fear that the interaction could lead to deportation or family separation affects the healing relationship/partnership
- A structural approach
  - Requires acknowledgment of the host of social factors and forces that affect health and operate to either include or exclude individuals and communities
  - Shift from micro individualism and behaviorism to macro upstream structural factors

Now, lets take a deeper look at a specific social determinant of health: Immigration. Historically, immigration has not been considered part of the social determinants of health. However, deeper understanding of the influences before, during, and after migration are important in the health care system in order to serve, prevent, and treat according to specific needs. First, at the micro level, being an immigrant limits behavioral choices (due to access and availability) and directly impacts and significantly alters the effects of other social positioning (respect, social capital). In order to unpack immigration as a social determinant of health, let's look at it through a macro structural lens.

Castaneda's Structural Framework:

"Immigration involves challenging adaptations that are more than processes of individual adjustment to new environments or cultural assimilation or acculturation to new sociocultural contexts; it is also a complex and often protracted process of negotiation with social structural, political, and economic forces. Thus, we recommend that, to make substantive improvements in health outcomes, immigration must be understood as a key social determinant of health in its own right. Immigration influences all other social relationships and is a lived experience that directly affects health and well-being."

"This framework interprets health outcomes through understanding and accounting for the

large-scale social forces that impact health… Scholarship in public health that takes a structural approach to understanding limited health care access among immigrant communities includes analyses of the social and policy determinants, such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), a pattern that is expected to continue for many immigrants under the Affordable Care Act of 2010."

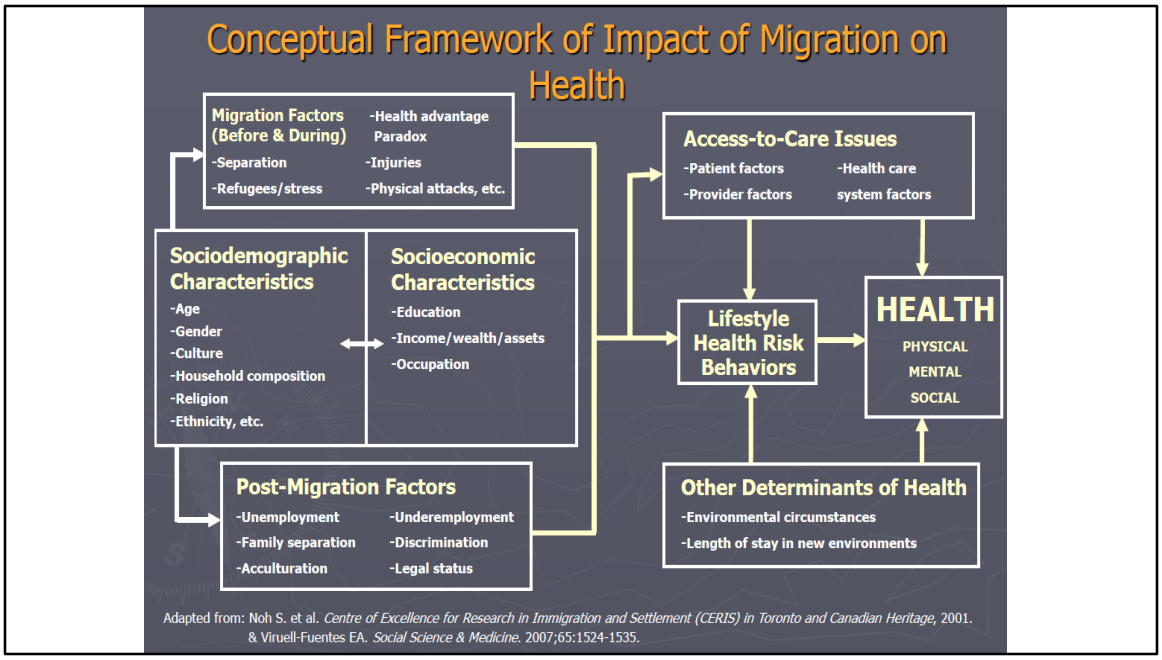
"This analysis of the structural factors impacting access to health care is the largest focus within the structural framework; however, access is often one of the downstream results or products of larger structural conditions. The second, less common area in this framework explores the general impacts of immigration status, specifically how immigration status impacts immigrants' ability to access health-protective resources. Status-related impacts include social, economic, and political factors that are external to immigrant bodies and that are shaped by local and national policies, such as housing conditions, neighborhood safety, and labor protections. For a few of these factors, immigrants are explicitly excluded from resources that other US residents receive (e.g., preventive care, certain labor protections). For other factors, immigrants experience challenges similar to those of other low-income communities of color (e.g., poor housing quality, poor neighborhood safety). The additional burden that immigrants face, however, is that they often choose not to interact with government services that could provide some relief to their situations out of fear that the interaction could lead to deportation or family separation. "

"A serious consideration of immigration in this light is consistent with and advances public health as a science that examines and responds to causes of disease on a population level. Treating immigration as a social determinant of health poses challenges to conventional understandings and practices because it requires going beyond the hold of individualism and behaviorism in public health and instead requires tackling a wider sphere of upstream structural factors affecting health. These include more inclusive health care practices, engagement with immigrant communities, and advocacy for fair immigration, economic, and health policies."

Reference:

Castaneda H, Holmes S, Madrigal D, Young M, Beyeler N, Quesada J. Immigration as a social determinant of health. In: Vol 36. Palo Alto: Annual Reviews; 2015:375-392.

Photo credit: Diego Huerta



Here is a visual representation of the impact of migration on health. The conceptual framework above focuses on the factors before, during, and after migration that have the potential of being traumatic.

As practitioners, we must remember that trauma is intergenerational because bodies do not just tell stories, they also share histories (Walters et. al, 2011 (a)). Historical trauma is defined as “event or set of events perpetrated on a group of people (including their environment) who share a specific group identity (e.g., nationality, tribal affiliation, ethnicity, religious affiliation) with genocidal or ethnocidal intent (i.e., annihilation or disruption to traditional lifeways, culture, and identity)” (Walters et al, 2011 (b)). Historical trauma can be considered to be a social determinant of health because of the “physical health reflects, in part, the embodiment of historical trauma” (Walters et al, 2011 (b)).

On the other hand, intergenerational trauma is defined as “natural disasters and other events that are man-made but not targeted with intention upon a particular group for social, cultural, ethnic, or political decimation or annihilation” (Walters et al, 2011 (b)). Both historical trauma and intergenerational trauma become embodied due to how we interact with our environment, which then impacts how our genes

manifest their regulation and expression (Krieger & Smith, 2004). The concept of embodiment has garnered interdisciplinary acceptance because it considers the interconnectedness of being human and the consequences of how our minds, bodies, and spirits interact with the environment intergenerationally. For instance, maternal psychological and nutritional stress during pregnancy are associated to biological consequences that predispose the next generations to stroke, hypertension, diabetes, and coronary heart disease (Kuwaza & Sweet, 2009). Nevertheless, the spectrum of responses to traumatic circumstances lends an opportunity to promote socio-cultural protective factors such as resistance, positive coping and resiliency, all of which can buffer the impact of such traumatic events on health outcomes.

For example, it is worth considering how trauma affects behavioral development, which "is thought to result from the interplay among genetic inheritance, congenital characteristics, cultural contexts, and parental practices as they directly impact the individual." Further regarding ancestral/transgenerational continuities, "evolutionary ecology points to another contributor, epigenetic inheritance," which refers to the fact that some "phenotypic responses made by the parent to environmental challenges may be displayed by offspring even though the offspring themselves do not encounter the challenge. It might be likened to a kind of phenotypic inertia: There is no change in genetic inheritance, but gene expression (the phenotype) is altered in subsequent generations, thereby resulting in intergenerational continuity—even when the young never experience the conditions that led to the parental trait." This means that trauma can be transmitted and embodied vicariously: instead of only vertical (from parents) transmission it can also be horizontal (from siblings, friends, acquaintances). This transmission has the power to "constrain the possible range of variation in offspring's reaction to environmental influences." However, it is hopeful to note that "intergenerational modifications are not necessarily permanent; when the precipitating conditions occur cyclically and remain absent for several generations, the phenotypic alterations 'decay' gradually" (Harper, 2005).

Let's further understand the biology of maternal effects from Harper's paper. According to Lacey (1998), "environmentally induced parental effects on offspring have been demonstrated in almost all living organisms, affecting traits ranging from egg size, growth rate, and resistance to pathogens to behavior. These parental effects can impact offspring development at a number of points in time: while the (maternal) gametes are developing prior to fertilization and in the post-fertilization and prenatal phases, as well as postnatally" (Wade, 1998). For example the intergenerational impact can be seen when "maternal stress during the latter half of a daughter's gestation [affects] not only the daughter's but also grand-offspring's physical growth" (Harper, 2005).

This intergenerational transmission of trauma with physical as well as mental

consequences has been not only been anecdotally but also empirically noted, especially on the descendants of populations who themselves survived traumatic events (e.g. Holocaust survivors). The lessons learned from these populations have been extrapolated to other less extreme forms of stress, "where differential physical, behavioral, and cognitive outcomes are observed in affected offspring." For example, "offspring of stress- or trauma-exposed parents may be at greater risk for physical, behavioral, and cognitive problems, as well as psychopathology." Specifically, "parental stress can be transmitted via gametes, the gestational uterine environment, and early postnatal care... Stress effects that are inherited via an 'intergenerational transmission' mode are reflected in offspring biological changes, including neuroendocrine, epigenetic, and neuroanatomical changes" (Bowers & Yehuda, 2016). This burden of consequences provides clues in the understanding the root causes of how stress can affect not only the physical, but also the mental and behavioral health of the future generations throughout their life course.

Bottom line, whether a person directly or indirectly experiences the trauma of migration, the effects are intergenerational and we must further focus on patient-centered and trauma-informed care.

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Kuzawa, Christopher W. and Elizabeth Sweet (2009). Epigenetics and the Embodiment of Race: Developmental Origins of US Racial Disparities In Cardiovascular Health. *American Journal of Human Biology*, 21(1): 2–15.

(a) Walters K, Mohammed S, Evans-Campbell T, Beltran R, Chae D, Duran B. Bodies Don't just tell stories, they tell histories. Embodiment of Historical Trauma among American Indians and Alaska Natives. Du Bois Review- Social Science Research on Race. 2011;8:179-189.

(b) Walters, Karina L., Ramona E. Beltran, David Huh, and Teresa Evans-Campbell. (2011). Dis-placement and Dis-ease: Land, Place and Health among American Indians and Alaska Natives. In Linda M. Burton, Susan P. Kemp, ManChui Leung, Stephen A. Matthews, and David T. Takeuchi (Eds.), *Communities, Neighborhood, and Health: Expanding the Boundaries of Place*, pp. 163–199. Philadephia, PA: Springer ScienceBusiness Media, LLC.

Lacey, E. P. (1998). What is an adaptive environmentally induced parental effect? In T. Mousseau & C. W. Fox (Eds.), *Maternal effects as adaptations* (pp. 54–66). New York: Oxford University Press.

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Migration and Mental Health

- Survivors of continuous traumatic stress
- When compared to other minorities and even whites, Latinx are more susceptible to PSTD
  - Higher rates of PSTD among immigrants from Central America and Mexico than native-born Americans
    - Due to exposure to political turmoil & violence related to drug wars
    - Concept of differential vulnerability
      - Ethnic minorities are more affected by stressors, regardless of whether they are similarly or differently exposed (Perilla, Norris, & Lavizzo, 2002).

Stress is part of the universal human experience. As a species we have evolved to respond to threats in the environment and through surviving those challenges, we learn the best strategies to cope. However, when that ability to react is overused, mental and physical problems arise. Such is the case with Posttraumatic Stress Disorder, which is a diagnosis that means that an individual "exposed to actual or threatened death, serious injury, or violation" experiences a clinical impairment in day to day living and functioning. Although there is no exclusive etiology, research has identified a complex mix of intersectionalities for the onset of PSTD. These characteristics include: inherited mental health risks, life experiences, inherited aspects of personality, and hormonal as well as chemical regulation of the stress response. According to the DSM-V, the diagnostic criteria encompasses 4 different exposure pathways. The first route of exposure is that the person directly experiences the traumatic event themselves. Second, the person witnesses the event. Third, a person learns of a trauma whether violent or accidental that occurred to a loved one. Lastly, a person experiences first-hand repeated or extreme exposure to details of a traumatic event. Symptomatology regarding behavior includes re-experiencing and intrusion, avoidance, negative cognitions and mood, and arousal and reactivity. In order to be diagnosed, the DSM-V requires that a disturbance continues for over a month as well as no association between substance abuse and symptoms (APA,

2013).

It is worth noting that manifestation of symptoms varies cross-culturally. For example, immigrant Latinx experience symptoms that include “loneliness, isolation, concentration difficulties, lowered interest levels, and feeling of hopelessness about the future,” which appears similar to the criteria for depression. Among the immigrant population a trend was found concerning the correlation between PSTD and “anxiety, somatization, and generalized distress” (Cervantes, Salgado de Snyder, & Padilla, 1989).

Furthermore, given the war on drugs throughout Latin America, it is relevant to address the intersectionality between trauma and migration. Although not official in the DSM-V, continuous traumatic stress- first proposed by Judith Herman in 1992- consists of repeated exposure to long- term stress rather than single-event traumas. This term illuminates the consistency of stress due to the before, during, and after migration process because it takes into consideration experiences such as: heinous violence in the country of origin, impunity, border crossing, acculturation to new host society, and fear of law enforcement even if legally present given racial profiling and police brutality.

Studies reveal that when compared to other minorities and even whites, Latinx are more susceptible to PSTD. This health disparity is explained by the concept of differential vulnerability, which “implies that ethnic minorities are more affected by stressors, regardless of whether they are similarly or differently exposed” (Perilla, Norris, & Lavizzo, 2002). This understanding of susceptibility accepts the ecological view that explains stress responses based on the context in which they are experienced. The variables influencing symptoms include “greater frequency and severity exposure to trauma, peritraumatic dissociation, wishful thinking, self-blame coping, and perceived racism” (Pole et al., 2005).

To be more specific regarding prevalence, higher rates of PSTD are reported among immigrants from Central America and Mexico than native-born Americans due to exposure to political turmoil, violence related to drug wars, and wars in general. A difference was seen between immigrant and non-immigrant Latinx groups in terms of “generalized distress and demoralization” for the former (Cervantes, Salgado de Snyder, & Padilla, 1989). For example, the most recent statistics, reveal that “35% of Hispanics of Mexican origin were born in Mexico. And while the remaining two-thirds (65%) were born in the U.S., half (52%) of them have at least one immigrant parent” (Gonzalez-Barrera & Lopez, 2013). These numbers reveal the direct connection to trauma due to personal or vicarious exposure.

Besides PTSD, the article by Gonzalez & Gonzalez (2008) cites evidence of general mental

health status before and after migration. For example, Vega et al (1998) "investigated the lifetime prevalence rates for psychiatric disorders, including depression, in 3,012 Mexican adults. Findings were then compared with population studies conducted in Mexico in which Mexican immigrants reported only half of the mental disorders as did Mexican Americans. Mexican immigrants reported experiencing significantly fewer depressive symptoms (5.2 %) than Mexican Americans (14.8%)."

An extensive body of literature has found that Mexican immigrants tend to have "better psychological profiles than Mexican Americans (Vega, *et al.,* 1998), lending further support to the Hispanic paradox that despite lower socioeconomic status and other disadvantages, Mexican immigrants have better mental health profiles than Mexican Americans (Escobar, 1998) and non-Hispanic white groups (Scribner, 1996)." However this healthy finding should not detract efforts of screening and service provision.

Let's remember that the act of migration is experienced differently by different people. The next layer, is that even if the migration itself was not traumatic, then being a migrant in an unwelcoming environment is a risk factor. Let's not discount this population just because they appear healthy due to their resilience.

For more info on CTSD, visit: https://www.psychologytoday.com/blog/media-spotlight/201305/when-the-trauma-doesnt-end

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Weathering Hypothesis

- Initially applied to reproductive-age women and birth outcomes
- The chronic exposure and survival of socially structured stressors
  - Cumulative biological impact
  - Increases health vulnerability and accelerates aging
    - Challenges metabolic homeostasis and promotes the early onset of chronic conditions
- Results from the qualitatively different life experiences, exposure to stressors, and access to coping resources
  - From conception through at least middle adulthood

The Mind/Body Medical Institute Professor of Medicine at Harvard Medical School, concluded that stress is responsible for up to 90% of all doctor visits (Benson, 1997).

The Geronimus et al (2015) article expanded on the populations at risk of the weathering effect, “while initially applied to reproductive-age women and birth outcomes, the weathering hypothesis also has been studied in the context of population differences for men and women across the life span (Geronimus 2001; Geronimus et al. 2006, 2007).”

The weathering hypothesis suggests that “the cumulative biological impact of being chronically exposed to, and having to cope with, socially structured stressors can increase health vulnerability and accelerate aging in marginalized populations (Geronimus 1992; Geronimus et al. 2006, 2010). In other words, structurally rooted biopsychosocial processes work through biological mechanisms to impact health.” So much so that “everyday challenges shaped by social disadvantage may trigger repeated activation of physiological stress processes (Geronimus 1992, 2001; Geronimus et al. 2006, 2010; McEwen 1998b; Sapolsky, Romero, and Munck 2000).” Further, “prolonged psychosocial or physical challenges to metabolic homeostasis can increase disease susceptibility and promotes the early onset of chronic conditions

(Geronimus et al. 2007; Geronimus and Thompson 2004; James 1994; Steptoe et al. 2002)."

This hypothesis also highlights that "population differences in the early onset of chronic disease result from the qualitatively different life experiences, exposure to stressors, and access to coping resources associated with salient social identities or assignments such as race or ethnicity, from conception through at least middle adulthood" (Geronimus et al., 2015).

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Allostatic Load

- Overexposure to stress hormones→ wear and tear on important body systems
  - lends biological plausibility to the weathering hypothesis.
- Humans respond to stressors through the cooperative effects of the primary stress response systems—the sympathetic nervous system (SNS) and hypothalamicpituitary-adrenal (HPA) axis (Sapolsky et al., 2000).
- With repeated activation of the stress response systems, these mechanisms become inefficient, resulting in an allostatic load on the body's systems (McEwen, 1998a).
  - Contributes to the development or progression of a broad range of clinical and preclinical pathological processes
    - Cardiovascular disease, obesity, diabetes, susceptibility to infection, carcinogenesis, and accelerated aging

Pre-peri-post migration experiences affect stress levels, which are compounded by factors such as educational attainment as well as political, economic, and social standing. Intuitively, the higher SES and educational level the lower the risk of PTSD (Roberts et al., 2011). However, Latinx migrants-especially Mexicans- who cross the border escaping the recent drug wars are often not in the privileged cohort of those resourceful enough to navigate the legal process with agency and dignity. Once the border crossing experience is survived, immigrants have to deal with acculturative stress. This type of stress creates dissonance of values, codes of conduct, and expected practices that may lead to culture shock. For example, language barriers represent a limitation to integration. Another instance is perceived discrimination and systematic racism that becomes internalized as chronic stress, which in turns creates a vicious cycle rendering migrants vulnerable to acculturation trauma. This survival involves "activation of neural, neuroendocrine and immune mechanisms" that contribute to "stability through change" capabilities that are deteriorated by the consequences of overstimulation. The condition of not being able to perform normally is called allostatic load, this is the "price of adaptation" which translates into cascading effects due to lack of effective coping and thus development of disease (McEwen & Stellar, 1993). So much so that studies have revealed that "after multivariate adjustment, acculturation items predicted greater risk of having any

DSM-III disorder for Mexican-Americans" (Ortega et al., 2000).

Therefore, it has become widely accepted that allostatic load influences the development or progression of clinical and preclinical pathological processes. So far data exits on allostatic load influences on cardiovascular disease, obesity, diabetes, susceptibility to infection, carcinogenesis, and accelerated aging (Geronimus et al. 2010; Geronimus and Thompson 2004; Khansari, Shakiba, and Mahmoudi 2009; McEwen and Seeman 1999). Above all, data exists providing an association between allostatic load and poor birth outcomes (Lu & Halfon, 2003). Even though the literature has yet to comprehensively explain it, "African Americans have 2.2 times the infant mortality rate as non-Hispanic whites. They are 3.5 times as likely to die as infants due to complications related to low birthweight as compared to non-Hispanic white infants" (Office of Minority Health). These disparities are finally obtaining attention and catalyzing action. Given this historically marginalized and oppressed group's experiences and outcomes, let our approach be proactive and prevention, and not reactionary and late. This way we can assuage their outcomes and mitigate the risks for other minority populations.

The racial disparity in birth outcomes is so stark between white and black infants that Lu et al., 2010, proposed a life course-centric agenda. Here is the 12-point plan "to reduce Black-White disparities in birth outcomes using a life-course approach. The first four points (increase access to inter-conception care, preconception care, quality prenatal care, and healthcare throughout the life course) address the needs of African American women for quality healthcare across the lifespan. The next four points (strengthen father involvement, systems integration, reproductive social capital, and community building) go beyond individual-level interventions to address enhancing family and community systems that may influence the health of pregnant women, families, and communities. The last four points (close the education gap, reduce poverty, support working mothers, and undo racism) move beyond the biomedical model to address the social and economic inequities that underlie much of health disparities."

Activity: How can you and/or your organization operationalize, contextualize, and optimize the 12-point plan?

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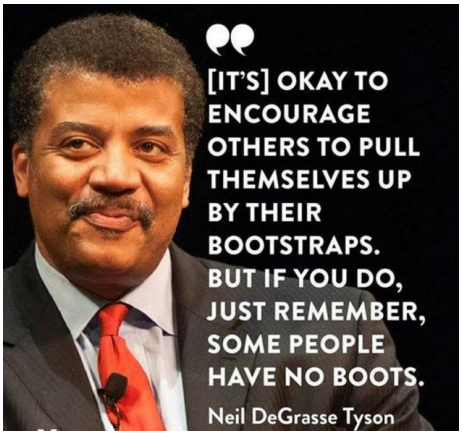
Telomeres

- Telomere length (TL)
  - Indicator of stress-mediated biological aging
- The weathering hypothesis interprets TL as a marker of accelerated aging that is biomechanistically impacted by repeated or chronic physiological stress process activation
- Residents of distressed urban areas suffer early aging-related disease and excess mortality
- Study in Detroit
  - Poor whites had shorter TL than nonpoor whites
  - Poor and nonpoor blacks had equivalent TL
  - Poor Mexicans had longer TL than nonpoor Mexicans
    - Poor Mexicans have longer TL on average than nonpoor whites and, therefore, net of covariates, the longest TL of the study groups.



Here is an example of how we can internalize our environment. Also, this study is a call-to-action in terms of funding for studies focusing on how the positive aspects of culture can help the health care system with resolving health disparities and inequities that directly affect intergenerational progress and development for women, maternal, and child health.

First let's understand the definition and purpose of telomeres. "Telomeres are the stabilizing caps on chromosomes that protect them from deterioration. They are made up of base pairs (DNA protein complexes). Telomeres shorten (lose base pairs) with cell division until a point at which the chromosomes are functionally impaired and exhibit genomic instability, resulting in cellular senescence or death (Blackburn, Greider, and Szostak 2006). Because cell division is necessary to replenish damaged cells, senescence could theoretically pose a serious problem in tissues and organs when a critical number of cells are no longer dividing." It is important to note that, "TL in an individual is determined by many factors, among them genetics, health behavior, cell environment, and physical environment" (Geronimus et al., 2015).

In a study by Geronius et al. (2015) in Detriot, poor whites had shorter TL than nonpoor whites, consistent with the previous findings. However, poor and nonpoor

blacks had equivalent TL given historical oppression and systematic racism regardless of SES. Interestingly, poor Mexicans had longer TL than nonpoor Mexicans. More so, poor Mexicans have longer TL on average than nonpoor whites and, therefore, net of covariates, the longest TL of the study groups.

More details:

For whites:
"Only whites showed results consistent with pervasive social epidemiological understandings—that is, the poor had shorter TL than the nonpoor—and this disparity was significantly reduced in models including the measured covariates. What might explain this? Perhaps, with the exodus of most whites and many jobs from Detroit, the shrinking benefits of labor union membership and public pensions, and the overall reduction in taxation-based city services, the poor whites who remain are particularly adversely affected by the social and ecological consequences of austerity urbanism. Lacking the financial resources, social networks, and identity affirmation of the past, remaining Detroit whites may have less to protect them from the health effects of poverty, stigma anxiety, or hopelessness in this setting (Geronimus 2000; Pearson 2008). To the extent that whites accept the American Creed ideology, they may be acutely sensitive to their perceived socioeconomic failures or, possibly, experience a version of status incongruity between expectations of white privilege and current circumstance that may be health harmful. Systematic exploration of such speculations may be a fruitful avenue for continued research."

For blacks:
"Much research suggests the separation between poor and nonpoor blacks in everyday life is less marked than between poor and nonpoor whites (Geronimus and Thompson 2004; Helflin and Pattillo 2006). Not only do blacks tend to have greater residential proximity owing to residential segregation, but often poor and the nonpoor blacks are members of the same families and social networks, practice reciprocal obligations, or have similar experiences of cycling between low and moderate incomes."

For Mexicans:
"Mexicans in the nonpoor group were disproportionately U.S. born, while those in the poor group were disproportionately foreign born. Moreover, 80% of all poor Mexicans reported that Spanish was the most commonly spoken language in their homes, regardless of nativity. Spanish speaking in the home may signal some protection from marginalization by offering an affirming cultural framework (James 1993; Pearson 2008). As James (1993) first suggested, Mexicans who are better able to maintain an alternative cultural framework to the dominant U.S. one that marginalizes them—in this case, as poor Mexicans in Detroit may have done to a

larger extent than nonpoor Mexicans—gain some protection from the health impacts of psychosocial and neighborhood stressors (Geronimus 2013b; Pearson 2008; ViruellFuentes 2007; Viruell-Fuentes et al. 2012). The finding that poor Mexicans reported feeling less anger or hopelessness than nonpoor Mexicans might be consistent with this finding."

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Resilience

- A universal capacity to prevent, minimize, or overcome the damaging effects of adversity (Grotberg, 1995).
  - Not invulnerable or "stress resistant," but rather competent or able to effectively adapt to one's environment
- Types
  1. Overcoming the Odds:
     - Attainment of positive outcomes despite high-risk environment
  2. Sustained Competence Under Stress:
     - Ability to cope with chronic environmental and interpersonal stress and maintain external equilibrium
  3. Recovery from Trauma:
     - Functioning well after an intensely stressful event

Although, there is no comparable word in Spanish, women understand the concept of overcoming adversity with courage, skills, and faith especially during their transition from womanhood to motherhood. A good way to think about resilience is that in physics, relaxation is the restoration of equilibrium following disturbance.

Resilience in real life can be understood as:

"Observing a normal or even exceptionally positive developmental outcome in spite of exposure to major risk for the development of serious social or health outcomes" (Fraser, Kirby, & Smokowski, 2004)

The bridge between surviving and thriving by faring well when confronted with adversity (Jenson & Fraser, 2016).

"The capacity to rebound from adversity, having to become strengthened and more resourceful" (Cox, 1978).

"Active process of endurance, self-righting, and growth in response to crisis and challenge" (Walsh, 2006).

"A dynamic process encompassing positive adaptation within the context of serious adversity" (Luthar, Cicchetti, & Becker, 2000).

"Good outcomes in spite of serious threats to adaptation or development" (Masten 2001, p. 228).

"The result of negotiations between individuals and their environments to maintain a self-definition as healthy" (Ungar, 2004, p. 23).

There are 3 types of resilience:

1. Think of the first type of resilience, or overcoming the odds, as the presence of protective factors that prevent the onset of a problem.
2. Sustained competence under stress can be understood as the presence of protective factors that mitigate the effects of a problem.
3. Recovery from trauma may also be referred to as "bouncing back" after experiencing a negative state instead of maintaining the problem condition.

As described by Cabrera (2013) in the Society for Research in Child Development's social policy report, "sources of resilience may be culturally-based, deriving from cultural traditions, values, languages, and strong ethnic identity."

For example, the report explains that "for first time in its history, half (49.9%) of American children under the age of five are of a non-White racial or ethnic minority group, according to 2012 U. S. Census Bureau estimates. In addition, the cognitive advantage of being bilingual or the strong social or oral narrative skills that some minority children bring to the classroom are developmental assets that can explain why some minority children exceed expectations (Gardner-Neblett, Pungello, & Iruka, 2012; Galindo, Fuller, 2010). Similarly, the formation of a strong ethnic identity can be an important predictor of positive outcomes for children (Phinney, Ong, & Madden, 2000; Smith, Levine, Smith, Prinz, & Dumas, 2009; Yip, Seaton & Sellers, 2006; Yip & Shelton, 2012)."

It is important to remember that research suggests that "the experience of 'everyday' and 'tolerable' stress may have benefits for children's development of self-regulatory and coping skills, such as having a greater propensity for resilience when adverse life events occur" (Seery, 2011). This means that not all of stress is bad nor created equal.

New research reveals that overall, minority children show strengths in at least 3 domains of development: social, language, and ethnic identity (Cabrera, 2013).

1. Social competence: "Self-regulation, defined as one's ability to manage one's

behavior, emotions, and attention voluntarily and adaptively, is strongly predictive of children's success in school. Self-regulated children are also likely to be socially competent (i.e., able to cooperate and get along with others), which also promotes school readiness."

a) For example, "Mexican American youth engage in relatively higher levels of prosocial behaviors—actions intended to benefit others—than European American youth" (Knight & Carlo, 2012).

2. Linguistic Strengths: "bilingual children are reported to have enhanced executive control in nonverbal tasks requiring conflict resolution as compared to monolingual children (Bialystok & Craik, 2010; Cummins, 2001; Diamond, 2010). However, there are also costs to being bilingual, at least initially, such as having smaller vocabularies and weaker access to lexical items."
3. Ethnic Identity: "the central premise of racial socialization research is that positive youth outcomes (competence, confidence, character, connection, and caring) are often directly supported through traditional racial socialization messages (e.g., preparation for bias, self-worth and egalitarianism; Evans et al., 2012). Security and pride in one's own racial and ethnic identity promote more positive peer and family relationships and self-esteem among racial and ethnic minorities (Neblett, Rivas-Drake, & Umaña-Taylor, 2012; Phinney, 1993). Consistent with the idea that a group-based identity might be helpful to youth, studies of collective efficacy—a sense of connectedness and willingness to intervene to encourage or sanction peer behavior among diverse African American, Latinx and majority youth—have shown that it is related to reduced problem behavior and substance use (Smith, Osgood, Caldwell, Hynes, & Perkins, 2013). "

Here are some guidelines to help foster resilience from the Grotber (1995) article:

To overcome adversities, children draw from three sources of resilience features labelled: "I HAVE, I AM, I CAN." It is important to mention that a resilient child does not need all of these features to be resilient, but they need at least one to be successful.

I HAVE: "People around me I trust and who love me, no matter what. People who set limits for me so I know when to stop before there is danger or trouble. People who show me how to do things right by the way they do things. People who want me to learn to do things on my own. People who help me when I am sick, in danger or need to learn."

I AM: "A person people can like and love. Glad to do nice things for others and show my concern. Respectful of myself and others. Willing to be responsible for what I do. Sure things will be all right."

I CAN: “Talk to others about things that frighten me or bother me, Find ways to solve problems that I face. Control myself when I feel like doing something not right or dangerous. Figure out when it is a good time to talk to someone or to take action. Find someone to help me when I need it.”

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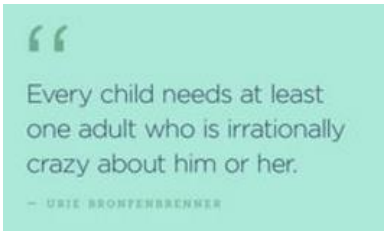
Protective Factors

- Favorable conditions that mitigate or protect the individual when exposed to risk factors, which creates a virtuous adaptation cycle of endurance and growth despite challenges and crisis (Walsh, 2003).
- More than the absence of negative outcomes
  - Need promotive factors too
    - Engagement and investment in school
    - Positive stress is growth promoting
    - Serve and return
  - Foster
    - Making meaning of adversity
    - Flexibility
    - Connectedness
    - Clarity
    - Open emotional expression
    - Collaborative problem solving



Protective factors can be understood as attributes or conditions that reduce or shield against risk while decreasing the probability of a negative outcome. Bender & Castro (2000) outline types of protective factors: "trusting relationships, emotional support outside the family, encouragement of autonomy and hope, responsible risk-taking, a sense of being lovable, unconditional love from someone, school achievement, a belief in God, and a strong moral sense. "

Protective factors (mitigate risk) and promotive factors (assets and resources) are needed since the beginning of life. For example, teaching how serve and return interaction builds a foundation for life because it shapes brain architecture is imperative. Practitioners can teach parents to be sensitive and responsive. For example, practitioner should explain that "when an infant or young child babbles, gestures, or cries, and an adult responds appropriately with eye contact, words, or a hug, neural connections are built and strengthened in the child's brain that support the development of communication and social skills" (Center for the Developing Child).

The Center of the Developing Child at Harvard, in the section of resilience also extolls "the single most common factor for children who develop resilience is at least one

stable and committed relationship with a supportive parent, caregiver, or other adult. They also build key capacities—such as the ability to plan, monitor, and regulate behavior—that enable children to respond adaptively to adversity and thrive." As seen in the quote above, this is the same philosophy of Urie Bronfenbrenner, the famous developmental psychologist who proposed the ecological systems theory of child development. Additionally, it is important to remember that resilience is not consistent and omnipresent since "individuals who demonstrate resilience in response to one form of adversity may not necessarily do so in response to another. Yet when these positive influences are operating effectively, they "stack the scale" with positive weight and optimize resilience across multiple contexts. These counterbalancing factors include facilitating supportive adult-child relationships; building a sense of self-efficacy and perceived control; providing opportunities to strengthen adaptive skills and self-regulatory capacities; and mobilizing sources of faith, hope, and cultural traditions." Lastly, there is hope along the life course because "the capabilities that underlie resilience can be strengthened at any age. The brain and other biological systems are most adaptable early in life. Yet while their development lays the foundation for a wide range of resilient behaviors, it is never too late to build resilience."

Cabrera (2013) provides an example of an intervention fostering promotive factors: Bridges to High School/Puentes a la Secundaria

"Bridges is a multi-cohort, experimental field trial of a culturally competent intervention to prevent school dropout and mental health disorders for low-income Mexican American adolescents (Gonzales et al., 2012). It is based on the idea that a central pathway for prevention of negative outcomes for Mexican-origin youth is through engagement and investment in school. School engagement is hypothesized to prompt a cascade of positive effects, so that promoting adaptive behaviors in one domain can influence adaptation in other domains (e.g., alcohol and drug use, high risk sexual activity, mental health, as well as school engagement). The program also tested whether school engagement mediated the effect of the intervention on multiple problem outcomes in late adolescence (5 years post test). *Bridges* significantly increased school engagement measured in the ninth grade, which mediated the intervention effects on internalizing symptoms, adolescent substance use, and school dropout in late adolescence (when most adolescents were in the 12th grade). Although originally developed and tested with a Mexican American population, the intervention has been generalized to all low-income populations. Interventions such as *Bridges* are important because they target several domains of development and thus may prove to be cost-efficient (e.g., address mental health issues but also impact key academic outcomes) and more likely to be adopted by communities."

Interventions like these are important given the expiration date of the health paradox. Gonzalez et al. (2012) explains that given that "Mexican American (MA) adolescents experience more emotional, behavioral, and academic problems than other ethnic groups in the United States. They are more likely than non-Latinx to use illegal drugs, carry a weapon on school property, and engage in other delinquent behaviors (Bird et al., 2001; Centers for Disease Control and Prevention, 2006; Grant et al., 2004). MA adolescents also report more depressive symptoms, compared with other U.S. ethnic groups (e.g., Roberts & Chen, 1995), and substantially higher rates of school failure (U.S. Dept. of Education, 2000). Interventions that can reduce these disparities are critically needed because MAs are the largest and fastest growing ethnic subgroup in the United States (U.S. Census Bureau, 2009)."

Walsh (2003) recommends that for protective factors to work, practitioners should help patients in "making meaning of adversity, having a positive outlook, being flexible, staying connected, and being willing to tap into social and economic resources." When engaging in communication, a practitioner should model "clarity, open emotional expression, and invite collaborative problem solving."

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Risk Factors

- Counterpart to protective factors (deficits)
  - Probabilities that facilitate the occurrence, exacerbation, or maintenance of a negative outcome (Fraser & Terzian, 2005).
  - In context, social and psychological example: social isolation
- Food insecurity, homelessness, living in poverty, unsafe neighborhoods, domestic violence, environmental pollution, inadequate education opportunities, racial discrimination, being born low birthweight, and lack of access to quality health services.

The social determinants of health refer to the protective, promotive, and risk factors present in an individual's life. Risk factors are the antithesis to protective factors– "any event, condition, or experience that increases the probability that a problem will be formed, maintained, or exacerbated" (Fraser & Terzian, 2005, p.5). All in all, risk factors render the individual more susceptible to exposures that yield unfavorable consequences (Jenson & Fraser, 2016).

Fine and Kotelchuck (2010) provide a helpful distinction of protective vs risk factors. "Throughout the lifespan, protective factors improve health and contribute to healthy development, while risk factors diminish health and make it more difficult to reach full developmental potential. Thus, pathways are changeable. Further, risk and protective factors are not limited to individual behavioral patterns or receipt of medical care and social services, but also include factors related to family, neighborhood, community, and social policy."

"Examples of protective factors include, among others: a nurturing family, a safe neighborhood, strong and positive relationships, economic security, access to quality primary care and other health services, and access to high quality schools and early care and education" (Fine & Kotelchick, 2010).

“Examples of risk factors include, among others: food insecurity, homelessness, living in poverty, unsafe neighborhoods, domestic violence, environmental pollution, inadequate education opportunities, racial discrimination, being born low birthweight, and lack of access to quality health services” (Fine & Kotelchick, 2010).

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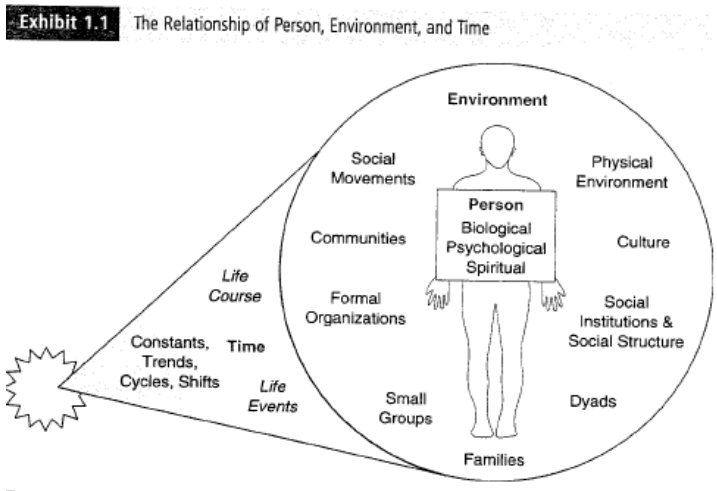
Life Course Theory



In order to understand the foundation and cumulative effects of risk, protective, and promotive factors, we must look at life course theory. Life Course is a framework that seeks to understand, explain, and improve health and disease patterns across population groups (Hutchison, 2008, p.9). The life course perspective is a developmental theory that allows exploration through a continuum lens of choices, interdependency, and intersectionality (Elder, 1998). Life-course theory has an

emphasis on plasticity at all ages/both early and later experiences are important.

Mainly, the theory focuses on "how chronological age, relationships, common life transitions, and social change shape people's lives from birth to death" (Hutchison, 2011, p. 8).

This idea of studying the intersection of person, environment, and time acknowledges Lipton's (2005) research on behavioral epigenetics, which "explains how being optimistic and fostering social connections can enable your cells to thrive"

throughout the life course. With the understanding that “our bodies can synthesize experience into biology,” we can design, implement, monitor, evaluate, and continuously engage in quality improvement for interventions that assuage health inequities through systematic health transformation.

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Life Course Concepts

- Transitions
  - Changes in roles and statuses
- Life events
  - Any significant occurrence involving a relatively abrupt change
  - Birth is a life event but motherhood is a transition
- Turning points
  - A substantial change or discontinuity in direction --- it serves as a lasting change---twists and turns and reversals
- Trajectories
  - Longer view of long-term patterns of stability and change in a person's life
- Timeline
  - Today's experiences and exposures influence tomorrow's health
- Timing
  - Health trajectories are particularly affected during critical or sensitive periods

Here are the life course theory's basic concepts as defined by Fine & Kotelchuck (2010) :

Cohort: a group of people who were born at same historical time, experience social changes within a given culture in the same sequence and at the same age

Transitions: changes in roles and statuses that represent a distinct departure from prior roles and statuses (birth, death, enter school, etc.)

Life events: major events such as 9/11, death of a parent or any significant occurrence involving a relatively abrupt change that may have life long effects. The difference between event and transition is that the transition is more of a change in role or status. For example, birth is a life event, but motherhood is a transition.

Turning points: a point in the life course that represents a substantial change or discontinuity in direction. A turning point serves as a lasting change. For example, twists, turns, and reversals in our life course (life events that close or open opportunities, make a lasting change on the person's environment, change a person's self-concept, beliefs, or expectations).

Trajectories: involve a longer view of long-term patterns of stability and change in a person's life. Trajectories involves multiple transitions.

Timeline – health is cumulative and longitudinal, i.e., developed over a lifetime.

Timing - health and health trajectories are particularly affected during critical/sensitive periods.

Environment – the broader environment (biologic, social, physical, economic) affects health and development.

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Fine, A. & Kotelchuck, M. (2010). Rethinking MCH: The Life Course Model as an Organizing Framework. Concept Paper. USDHHS. Health Resources and Services Administration. Maternal and Child Health Bureau. Available at: https://www.hrsa.gov/ourstories/mchb75th/images/rethinkingmch.pdf

Photo credit: Diego Huerta

Birth Outcomes and Life Course Perspective

- Early Programming Mechanism
  - Adverse programming can either result directly in a disease or condition, or make an individual more vulnerable or susceptible to developing a disease or condition in the future.
  - Includes prenatal programming
    - Exposure in utero
  - Intergenerational programming
    - The health of the mother prior to conception
- Cumulative Pathways Mechanism
  - Direct or indirect impact
    - Indirect impact via associated behavioral or health service seeking changes
  - Wear and tear takes a toll on health and functioning
  - Allostatic load builds up over time
- Solution: consider differential exposures to risk, protective, and promotive factors during the whole life course during assessment and treatment plan

Now let's apply life course theory to birth outcomes. Life course theory provides an explanation to the "disparities in birth outcomes due to differential developmental trajectories of the mother, based on early life experiences (programming) and cumulative stress (Fine & Kotelchuck, 2010).

Fine & Kotelchuck, 2010, explain these concepts further:

Pathways or Trajectories – "Health pathways or trajectories are built – or diminished – over the lifespan. While individual trajectories vary, patterns can be predicted for populations and communities based on social, economic and environmental exposures and experiences. A life course does not reflect a series of discrete steps, but rather an integrated continuum of exposures, experiences and interactions."

Early Programming – "Early experiences can "program" an individual's future health and development. This includes prenatal programming (i.e. exposure in utero), as well as intergenerational programming (i.e., the health of the mother prior to conception) that impact the health of the baby and developing child. Adverse programming can either result directly in a disease or condition, or make an individual more vulnerable or susceptible to developing a disease or condition in the

future."

Critical or Sensitive Periods – "While adverse events and exposures can have an impact at any point in a person's life course, the impact is greatest at specific critical or sensitive periods of development (e.g., during fetal development, in early childhood, during adolescence, etc.)."

Cumulative Impact – "Cumulative experiences can also 'program' an individual's future health and development. While individual episodes of stress may have minimal impact in an otherwise positive trajectory, the cumulative impact of multiple stresses over time may have a profound direct impact on health and development, as well as an indirect impact via associated behavioral or health service seeking changes. (This concept of cumulative impact is also referred to as 'weathering' or 'allostatic load')."

Lu & Halfon (2003), explain the early programming model and the cumulative pathways mechanism:

"The cause of these persisting racial disparities remains unexplained. Most extant studies focus on differential exposures to protective and risk factors during pregnancy, such as current socioeconomic status, maternal risky behaviors, prenatal care, psychosocial stress, or perinatal infections. These risk factors during pregnancy, however, do not adequately account for the disparities. The early programming model posits that exposures in early life could influence future reproductive potential. The cumulative pathways model conceptualizes decline in reproductive health resulting from cumulative wear and tear to the body's allostatic systems. We propose a synthesis of these two models, using the life-course perspective. Disparities in birth outcomes are the consequences of differential developmental trajectories set forth by early life experiences and cumulative allostatic load over the life course." They conclude that "future research on racial disparities in birth outcomes needs to examine differential exposures to risk and protective factors not only during pregnancy, but over the life course of women. Eliminating disparities requires interventions and policy development that are more longitudinally and contextually integrated than currently prevail."

Therefore, practitioners should examine differential exposures to risk, protective, and promotive factors during the whole life course during their assessment and treatment plan.

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Applying Risk and Resilience to Practice

- Consider:
  - What short term and long term problems does the patient face?
  - What goals/outcomes does the client want to achieve?
  - Which risk, protective, and promotive factors are the most influential?
  - Which risk factors can be modified?
    - Which protective and promotive factors can be mobilized given the skills and resources available?

Let's apply the risk and resilience throughout the life course model to practice.

First, consider the social work framework of meeting patients where they are at in that moment. Next ask the questions above and have someone in your multi-disciplinary team complete a life event inventory to get a sense of the level of stress in the patient's life. It is healing to help clients make sense of their unique life journeys and understand how micro and macro forces influence health outcomes. As a practitioner, you must strive to understand, acknowledge, and validate the impact of historical context on patients' lives.

Overall, life course theory tells us that interventions, which are empoweringly co-created with the individual/community reduce risks and increase protective factors. These outcomes benevolently change the health trajectory of individuals and populations. This fact motivates us as practitioner to advocate for better linkage and synergy of (vertical, horizontal, and temporal) interventions. In order for progress to develop and be sustainable, people must feel appreciated and in control. Once that a sense of ownership, responsibility and pride reign, then they will be the driving forces to achieve the intended results because the stakeholders have found meaning in the uptake (Greenhalgh et al., 2004). By virtue of having a shared decision-making

protocol, the capacity building suggestions become relevant, compatible, adaptable, and integrated into the existing modus operandi of the individual/community, which make the theory of change feasible (Durlak et al., 2008).

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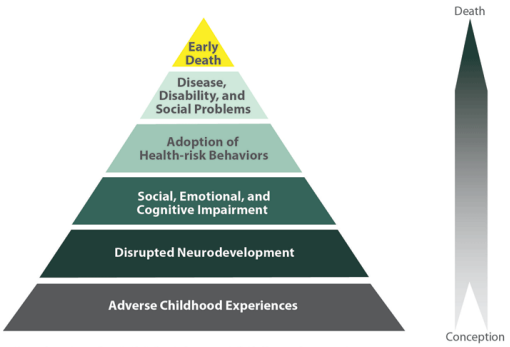
Photo credit: Diego Huerta

ACES study

- Dr. Robert Block, the former President of the American Academy of Pediatrics, "Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today."
- 17,337 adult participants completed survey
  - Assessed retrospectively and prospectively: long-term impact of abuse and household dysfunction during childhood on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality
  - The original ACEs study was done in a population that was 70 percent Caucasian, 70 percent college-educated.
  - Revealed the power of toxic stress
- Solution: screening at regular physical visit



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Let's give some context to the content: Here is the famous study that utilizes the life course perspective by linking early adverse childhood experiences to adverse health across the lifetime.

The study began with a partnership between Kaiser Permanente and the U.S. Centers for Disease Control and Prevention. It looked at multiple categories of childhood physical and emotional abuse and neglect, as well as measures of household dysfunction like domestic violence, parental mental illness, substance abuse and separation/divorce (Center for Youth Wellness).

ACES are associated with

- Alcoholism and alcohol abuse
- COPD
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- IHD

- Liver Disease
- IPV
- Multiple sex partners
- STIs
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity

This study revealed the power of toxic stress, which unlike manageable stress, “refers to the long-term changes in brain architecture and organ systems that develop after extreme, prolonged and repeated stress goes untreated” (Center for Youth Wellness). The fact that exposure to adversity affects the developing body and brain reveals why the health paradox erodes over time.

The study design included assigning one point for every ACE (history of childhood exposure) experienced by the subject. Respondents were defined as exposed to a category if they responded “yes” to 1 or more of the questions in that category. Then, the authors correlated ACE scores against health outcomes. They found that ACES are common: 67 percent (2 out of 3 people) of the study population had at least one ACE and 12.6 percent (1 out of 8 people) of the population had four or more ACEs.

The authors also found that there was a dose-response relationship between ACES and health outcome. In other words the higher your ACE score, the worse your health outcome.

In her TED talk, Dr. Nadine Burke-Harris explains that “exposure to early adversity affects the developing brains and bodies of children. It affects areas like the nucleus accumbent-the pleasure and reward center of the brain that is implicated in substance dependence. It inhibits the prefrontal cortex, which is necessary for impulse control and executive function, a critical area for learning. And on MRI scans, we see measurable differences in the amygdala, the brain's fear response center. So there are real neurologic reasons why folks exposed to high doses of adversity are more likely to engage in high-risk behavior.” However, “it turns out that even if you don't engage in any high-risk behavior, you're still more likely to develop heart disease or cancer. The reason for this has to do with the hypothalamic–pituitary–adrenal axis, the brain's and body's stress response system that governs our fight-or-flight response.” “This is a problem of over activation of system, which goes from being adaptive and life saving to maladaptive and health damaging. This repeated stress activation is even more damaging for children whose brains and bodies are just developing. Bottom line, high doses of adversity not only affect brain

structure and function, they affect the developing immune system, developing hormonal systems, and even the way our DNA is read and transcribed."

Solution:

As providers we must make a commitment to utilizing trauma-informed care given the unfortunate omnipresence of trauma. For more information visit: https://www.samhsa.gov/trauma

According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:"

1. *"Realizes* the widespread impact of trauma and understands potential paths for recovery"
2. *"Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system"
3. *"Responds* by fully integrating knowledge about trauma into policies, procedures, and practices"
4. "Seeks to actively resist *re-traumatization*."

Here are SAMHSA's Six Key Principles of a Trauma-Informed Approach:
"A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:"

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

Here are the Trauma-Specific Interventions

1. "The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery."
2. "The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety."
3. "The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers."

Here is another option with potential to address trauma and intergenerational trauma Dr. Nadine Burke Harris created the Center for Youth Wellness to prevent,

screen and heal the impacts of ACEs and toxic stress for every patient during their regular physical examination. So let's screen every patient for their ACE score and RESILIENCE score. While conducting the screening, we must shift from questions such as "what's wrong with you?" to "what's happened to you?"

The solution proposed in "ACES Too High" (a news site dedicated to report the latest research about adverse childhood experiences) of screening every patient during their wellness visit is feasible. The process starts with a family development specialist (FDS) or Social Worker who knows the resources in the community that are available to families. This is especially important to implement during prenatal visits. Providers must include the partner and rest of support system if the patient consents. Overall, the interaction should avoid blaming and shaming and consists of radical acceptance and compassion.

During the visit/session:
1st step: explain the basics of ACE science. Include a normalization of the omnipresence of childhood traumas. Explain how childhood experiences could be related to health. Acknowledge what they have been through and praise the strengths.
2nd step: give the 10-question ACE assessment and a 25-question resilience assessment (available in Spanish and English). Or build your own indicator, yet do not forget to ask about housing, employment, food, violence, abuse, bullying, racism, and childcare.
3rd step: share results with physician, who reviews it before talking with the family.
4th step: link parents with resources to reduce stress in the home

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(ACES). Available at: http://www.centerforyouthwellness.org/adverse-childhood-experiences-aces/

TED Talk by Dr. Nadine Burke Harris Available at: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime/transcript?language=en#t-403725

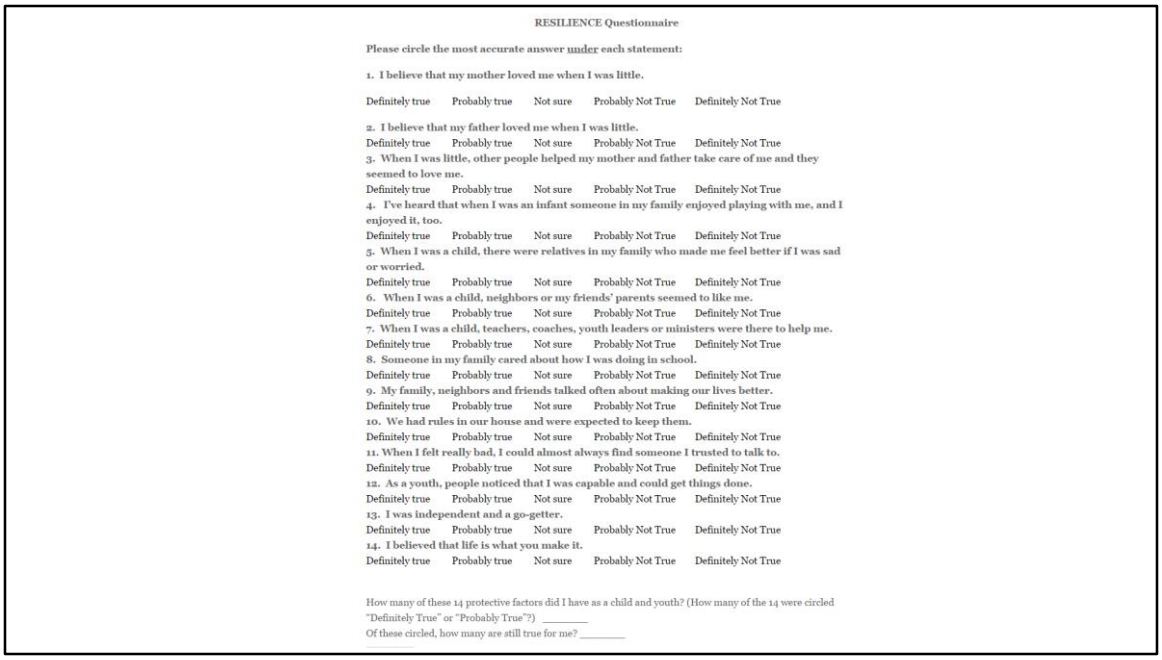
ACES Too High. Got Your ACE Scores. What's Your ACE Score? (and, at the end, What's Your Resilience Score?). Available at: https://acestoohigh.com/got-your-ace-score/

As a child, before your 18th birthday...	Circle YES or NO	
Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	Yes	No
Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes	No
Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No
Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes	No
Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No
Was a biological parent ever lost to you through divorce, abandonment, or other reason?	Yes	No
Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes	No
Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	Yes	No
Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No
Did a household member go to prison?	Yes	No
Add the number of YES's for your TOTAL ACES SCORE		

Here is the 10-question ACE assessment. Indeed, this brief assessment may not be capturing all the traumatic experiences that patients are experiencing or have experienced. So feel free to edit and contextualize it according to your needs. Take into consideration that depending on the population you serve, practitioners may also need to ask the same question in different ways. During the first visit, the goal is to ask about patient's history, document it, and assuage the situation in a collaborative, patient-centered way.

Reference:

ACES Too High. *Pueblo, CO, clinic rewrites the book on primary medical care by asking patients about their childhood adversity. Available at:* https://acestoohigh.com/2016/12/20/pueblo-co-clinic-rewrites-the-book-on-primary-medical-care-by-asking-patients-about-their-childhood-adversity/#more-6403



RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True
3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
Definitely true Probably true Not sure Probably Not True Definitely Not True
4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
Definitely true Probably true Not sure Probably Not True Definitely Not True
5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
Definitely true Probably true Not sure Probably Not True Definitely Not True
6. When I was a child, neighbors or my friends' parents seemed to like me.
Definitely true Probably true Not sure Probably Not True Definitely Not True
7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
Definitely true Probably true Not sure Probably Not True Definitely Not True
8. Someone in my family cared about how I was doing in school.
Definitely true Probably true Not sure Probably Not True Definitely Not True
9. My family, neighbors and friends talked often about making our lives better.
Definitely true Probably true Not sure Probably Not True Definitely Not True
10. We had rules in our house and were expected to keep them.
Definitely true Probably true Not sure Probably Not True Definitely Not True
11. When I felt really bad, I could almost always find someone I trusted to talk to.
Definitely true Probably true Not sure Probably Not True Definitely Not True
12. As a youth, people noticed that I was capable and could get things done.
Definitely true Probably true Not sure Probably Not True Definitely Not True
13. I was independent and a go-getter.
Definitely true Probably true Not sure Probably Not True Definitely Not True
14. I believed that life is what you make it.
Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____
Of these circled, how many are still true for me? _____

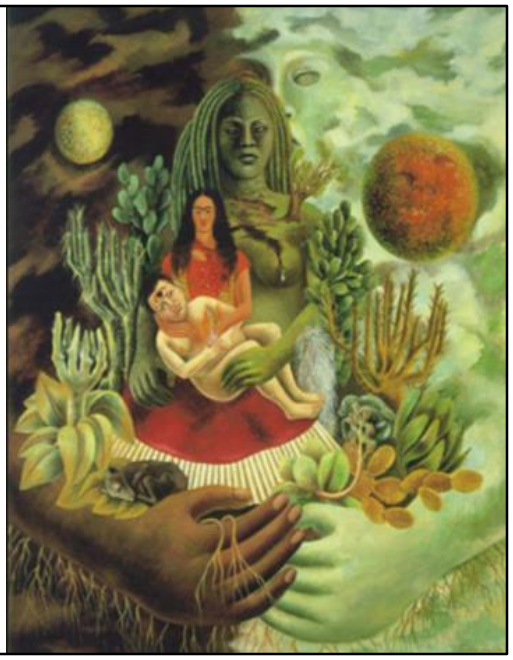
Here is an example of a resilience questionnaire. "This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions." As it was the case with the risk questionnaire, please free to edit and contextualize it according to your populations' needs.

Reference:

ACES Too High. Got Your ACE Scores. What's Your ACE Score? (and, at the end, What's Your Resilience Score?). Available at: https://acestoohigh.com/got-your-ace-score/

Faith & Optimism

- "An individual's fundamental sense of safety and well-being rests on the quality of the relationship they develop with an attachment figure" (Krause and Batisda 2011).
  - "People who possess a stable sense of attachment security generally feel safe and worthy…hold an optimist and hopeful outlook on life" (Shaver and Mikulincer, 2007).
  - Optimism promotes positive emotions
    - Believing that good rather than bad things will happen
- Spirituality and optimism positively affect both physical and mental health and are associated with decreased mortality risk (Skolarus et al., 2012).
- Older Mexican Americans who use their faith to find something positive in the face of suffering tend to rate their health more favorably.
  - In contrast, older Mexican Americans who believe that it is important to suffer in silence tend to rate their health less favorably (Krause & Batisda, 2011).



Now let's talk about the intersection of two protective as well as a promotive factors more in depth: Faith and Optimism.

In the literature review section of their study about optimism and health, Krause and Batisda found that a sense of optimism promotes positive emotions that may reduce the risk of developing mental health problems (Nunn, 1996) that may, in turn, influence physical health (Cohen & Rodriguez, 1995).

The data suggest that older Mexican Americans who attend church services more often find something positive when challenged by a problematic situation. The outcomes reveal that "searching for something positive in suffering is associated with developing a perceived close relationship with God." Therefore, older Mexican Americans who are more optimistic tend to rate their health more positively (Krause & Batisda, 2011).

Skolarus et al., (2012) reveal that "spirituality and optimism positively affect both physical and mental health and are associated with decreased mortality risk. For example, attendance at religious services was linked to increased life expectancy comparable in magnitude to both physical activity and statin use (Hall 2006). Among

MAs specifically, religion has been shown to have a protective effect on both depression and cognitive decline (Hill et al. 2005; Levin et al. 1996; Reyes-Ortiz et al. 2008). Additionally, increased optimism, defined as generally believing that good rather than bad things will happen, is associated with a faster rate of recovery and lower re-hospitalization following coronary artery bypass surgery, earlier return to normal activities following inguinal hernia repair, and decreased all-cause and cardiovascular mortality (Bowley et al. 2003; Giltay et al. 2004; Scheier et al. 1989, 1999; Tindle et al. 2009)."

Another intersecting layer is fatalism. Fatalismo is a culturally specific belief reassuring the individual that everything is as it should be because it is directed by God (Pole et al., 2008). According to Skolarus et al (2012), "Fatalism, defined as the belief in external control over life chances, is associated with other poor health behaviors such as decreased cancer screening (Peek et al. 2008; Perez-Stable et al. 1992; Randolph et al. 2002)." Regardless of the official definition, the important aspect is to know how the belief and practice of fatalism manifests in the patient. Therefore, as a practitioner, before you condemn or reinforce a behavior, unpack it.

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Photo Credit: Frida Kahlo

Cultural and Spiritual Traditions

	Pregnancy, Birth & Postpartum
Breastfeeding	• May believe breastfeeding provides protection from pregnancy
C-section	• May be feared
Genetic defects	• Usually described as will of God; may believe are a result of behavior
Labor	• Walking recommended to encourage a quick birth • Fears include unnecessary or dangerous medical interventions, separation from family members, & loss of privacy • Laboring women seen as strong & participatory • Family women may assist; may involve several
Postpartum	• May resist getting out of bed or taking showers for several days • Folk belief is to cover back & wear a wide cloth band around abdomen
Prenatal care	• May believe unnecessary • May use folk medicine; be sure to ask • Culture may prohibit pregnant women from caring for dying persons or attending funerals • Medications, including iron & vitamins, may be seen as potentially dangerous & avoided, even after delivery

Adapted from *A Quick Guide to Cultures & Spiritual Traditions*, By Sue Wintz, BCC & Earl P. Cooper, BCC

Here is a detailed list of cultural and spiritual traditions that may or may not be observed during pregnancy, birth, and postpartum. Even if they are observed, the degree of adherence or fidelity may vary.

Reference:

Intercultural Advantage: Consulting-Training-Research-Education. Available at: www.interculturaladvantage.com

Religiosity

- Religiosity does not revolve around Freud's 'I' ... but around the 'we.' ... it places family well-being, the good of the collectivity, above the individual good' (Figeroa, 1993).
- There are 3 aspects of religion (Yeary et al, 2012).
  - Behavioral
    - Religious attendance
      - Causal relationship with better health outcomes
  - Subjective
    - Religious commitment
    - Religious identity
  - Functional
    - Religious coping
    - Religious control-beliefs (God-mediated control)

"Religiosity refers to attitudinal dimensions such as belief in God, religious orthodoxy, commitment to a faith, and seeing one's religion as a source of strength. Religiosity may translate into health-related attitudes and actions derived from the particular religion's prescriptions and proscriptions about behavior and may involve individuals in social networks that exert behavioral norms. These behaviors in turn make it more or less likely that an individual will become ill or die" (Jarvis & Northcott, 1987).

Let's apply this knowledge:
According to implementation science, the implementation stages are not linear, yet serve as a guide to the "mission-oriented" process of "making full and effective use" of innovations. During the four stages (exploration, installation, initial implementation, and full implementation) one must consider context (AI HUB). When designing innovative interventions at the individual or community level 'place and space' should always be considered. For example, "church-based interventions have been utilized to access populations that are more difficult to reach via traditional mechanisms" (Campbell et al. 2007).

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Photo credit: Cornelio Campos

Role of Religion and Health

- Tendency to identify as Catholic is significantly higher for both Mexicans born in the U.S. and those born in Mexico
  - ~79% of Mexican Americans adults are Catholics
- Services
  - Ease immigrant settlement: stress buffer
  - Integration
  - Spiritual therapy
  - Source of social and economic support
    - Part of social capital component
- Consultation with religious leaders
  - Emotional: blessings
  - Instrumental:
    - Counseling and resources

TABLE 4. Number and percentage of all U.S. women of reproductive age, by sexual and reproductive health characteristics, according to race or ethnicity, National Survey of Family Growth, 2002

Characteristic	All women 15–44	Race or ethnicity* White	Black	Latina Total	Latina U.S.-born	Latina Foreign-born
Total						
No.	61,560,715	40,420,450	8,586,813	9,106,808	4,517,542	4,560,256
% ever had sex	88.0	88.5	89.6	86.6	81.6	91.6
% ever had a child	58.4	55.8	63.3	67.6	58.5	76.7
Sexually experienced						
No.	54,189,517	35,789,143	7,693,099	7,886,712	3,720,602	4,137,100
% used contraceptive at first	62.6	67.8	60.1	43.2	54.9	32.4
% used condom at first sex	35.5	38.2	33.7	25.4	33.7	18.2
At risk for unintended pregnancy†						
No.	42,683,183	28,754,730	5,799,582	6,075,089	2,804,209	3,243,888
% use sterilization	32.3	32.3	35.1	33.8	37.2	30.9
% use reversible method	57.0	58.4	49.9	54.6	51.0	57.6
% sexually active, using no method	10.7	9.4	15.1	11.6	11.8	11.5
Using a contraceptive						
No.	38,109,185	26,061,680	4,925,289	5,370,458	2,473,445	2,870,632
Distribution by most effective method used:						
% using female sterilization	27.0	24	38.9	33.8	35.7	32.3
% using male sterilization	9.2	11.6	2.4	4.4	6.5	2.6
% using implant/IUD	2.4	1.6	1.5	7.1	2.8	10.9
% using injectable	5.5	4.4	9.9	7.8	6.3	8.7
% using pill	30.6	34.3	22.5	22	23.4	20.6
% using condom	18.0	16.6	19.9	18.5	17.8	19.2
% using withdrawal	4.0	3.9	2.6	3.7	4.2	3.4
% using all other methods	3.3	3.5	2.3	2.8	3.3	2.3
% using a condom at all	23.8	21.8	29.6	24.1	22.7	25.6

†Number at risk for unintended pregnancy excludes women who are currently pregnant, trying to get pregnant, postpartum, noncontraceptively sterile or not sexually active in the past three months.
*White and black exclude Latinas. Latinas may be of any race. Women reporting "other" are not shown separately, but are included in the totals.

To use as a point of reference regarding the intersection of religion and sexuality, above is a table with the number and percentage of all U.S. women of reproductive age, by sexual and reproductive health characteristics, according to race or ethnicity from the National Survey of Family Growth in 2002 (Frost & Driscoll, 2006). Although the data does not reveal specific details regarding Mexican women, it gives us an estimate of U.S. born and foreign-born unmet needs.

A 2007 report by the Pew Hispanic Center conducted public opinion surveys where they found that "the tendency to identify as Catholic is significantly higher for both Mexicans born in the U.S. and those born in Mexico." The overwhelming majority (about 79%) of Mexican Americans adults are Catholics (Espinosa, 2008). Even though religious participation is a crude proxy for measuring the degree of religiosity, it is worth noting that by participation, the most public religious activity is church attendance with 45% of Mexicans confessing their presence. Also by participation, the most common private activity is prayer with 67% of Mexicans praying daily.

In terms of healthy coping strategies, religion is an important socio-cultural mechanism that the health paradox depends on to yield superior health outcomes. So much so, that "both men and women were more likely to turn to their religious faith for coping with their stressful situations than to any other form of personal

action" (Maldonado, 1995). The blueprint for behaviors that the Church sanctions most be considered when interventions are designed and implemented.

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Examples

- Promise/La Promesa:
  - Covenant between the believer and a sacred image
  - Vow of reciprocity
- Fasting/ Ayunos
  - Belief that prayers have a greater chance of being heard if you sacrifice food intake
- Medals/Scapulars
  - Represents the presence of God

Here are some examples that you may encounter in practice.

1. Promesa: In exchange of divine intervention or granting of request, the believer "promises" to perform certain acts in return of a favor.
2. Ayunos may serve a dual purpose given that some exams require fasting.
3. Wearing a medal or scapular is a physical reminder of the presence of God and protection. You might witness patients carrying amulets to fend off "el mal de ojo" or evil eye. For example, if you are going to give a compliment to a child, then be sure to touch them while adoring/praising them. This way you avoid "el mal de ojo."

Photo credit: Photo credit: Simón Silva
Titled: "Rezando"

Catholic Saints and Associated Health Conditions

Amputees	St. Anthony	**Lumbago**	St. Lawrence
Arthritis	St. James	**Medical Students**	Dr. Hernandez
Blindness	St. Lucy, St. Raphael	**Mental Illness**	St. Dymphna
Bodily Ills	Our Lady of Lourdes	**Midwives**	St. Raymond
Breast Cancer	St. Agnes	**Nerves**	St. Dymphna
Cancer Patients	St. Peregrine	**Nurses**	St. Agatha, St. Camillus
Childbirth	St. Anne, St. Gerard, St. Ramon	**Paramedics**	St. Luke
Children	St. Nicholas Infant of Prague	**Pharmacists**	Sts. Cosmos & Damian
Cranky Children	St. Sebastian	**Physicians**	St. Luke, St. Raphael
Desperation	St. Jude	**Plague Victims**	St. Roch
Dieticians	St. Martha	**Poison Sufferers**	St. Benedict
Dog Bite	St. Hubert	**Police Officers**	St. Michael Archangel
Druggists	St. Raphael Archangel	**Pregnant Women**	St. Gerard, St. Raymond
Dying	St. Barbara, St. Joseph	**Radiologists**	St. Michael Archangel
EMTs	St. Luke	**Rheumatism**	St. James
Epilepsy	St. Vitus	**Sick**	St. Camillus, St. Michael Archangel
Eye Diseases	St. Raphael	**Sick Poor**	St. Martin de Porres
Eyes	St. Lucy	**Skin Disease**	St. Peregrine, St. Lazarus of Dives
Fathers	St. Joseph	**Snake Bite**	St. Patrick
Fever	St. Peter	**Solitary Death**	St. Francis of Assisi
Firefighters	St. Florian	**Speedy Results**	St. Expedite, Infant of Prague
Foot Trouble	St. Peter	**Stomach Trouble**	St. Charles
Gout Sufferers	St. Andrew	**Surgeons**	Sts. Cosmos & Damian
Grandmothers	St. Anne	**Surgery Patients**	Infant of Prague
Happy Death	St. Joseph	**Throat Trouble**	St. Cecilia
Healing of Wounds	St. Rita	**Tongue Trouble**	St. Catherine
HIV-AIDS Patients	St. Lazarus of Dives	**Toothache**	St. Patrick
Hospital Staff	St. Martin de Porres	**Tuberculosis**	St. Theresa
Impossible Causes	St. Jude	**Tumor**	St. Rita
Incest Victims	St. Dymphna	**Ulcers**	St. Charles
Infertility	St. Anthony	**Undertakers**	St. Sebastian
Insanity	St. Dymphna		
Invalids	St. Roch		
Long Life	St. Peter		

Here is a reference list of catholic saints and their associated intercession powers with health conditions.

Practitioners can look at prayer as a special form of meditation. Specifically, spiritual meditation has been found to be superior to secular meditation and relaxation in terms of “decrease in anxiety and improvement in positive mood, spiritual health, spiritual experiences and tolerance to pain” (Wachholtz 2005).

Andrade et al (2009) described that “prayer is a special form of meditation and may therefore convey all the health benefits that have been associated with meditation.” He explains that prayer may be associated with the placebo response given the power of expectations, beliefs, and perceptions. Lipton (2005, p.136) defines the placebo effect as “when the mind, through positive suggestion, improves health.” A useful distinction between both concepts is that prayer is like talking to God and meditation is listening.

“Clinically significant treatment gains have been observed with placebo in numerous disorders, including anxiety, depression, schizophrenia, obsessive compulsive disorder, tardive dyskinesia, ischemic heart disease, cardiac failure, Parkinson's

disease and even cancer" (Andrade, 2009). This means that as practitioners we can leverage the placebo effect while avoiding the nocebo effect. The nocebo hypothesis "proposes that expectations of sickness and the affective states associated with such expectations cause sickness in the expectant" (Hahn, 1997). The nocebo effect refers to negative suggestions that lead to negative health or "the causation of sickness (or death) by expectations of sickness (or death)…without being the result of confounding variables" (Hanh, 1997). By words or demeanor, practitioners can convey hope-deflating messages that are unwarranted. For example, there is no need to offer up life expectancy to a patient. In other words, don't program anyone to believe there are powerless. In any case, the placebo/nocebo phenomenon suggests that it may be healthier to err on the side of optimism than on the side of pessimism" (Hahn, 1997).

In conclusion, "positive perceptions of the mind enhance health by engaging immune functions, while inhibition of immune activities by negative perceptions can precipitate disease" (Lipton, 2005).

Furthermore, "prayer may be associated with improvements that result from spontaneous remission, regression to the mean, nonspecific psychosocial support, the Hawthorne effect and the Rosenthal effect" (Andrade et al, 2009). "The Hawthorne effect refers to change that occurs as a result of the act of observation or measurement… The comforting environment of the study setting or the conscious or unconscious wish of the patient to please may result in the report of less symptoms than actually exist. The Rosenthal effect refers to change resulting from observer or rater expectancy... The tendency of the rater to expect symptom attenuation across time may result in the attachment of lower significance to reported symptoms."

Reference:

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Photo credit: Diego Huerta

La Virgen de Guadalupe

- Religious icon and sign of patriotism
- 1531 appearance to Juan Diego
- Patroness of Mexico
  - Mexico's most revered religious image
- Patroness of the Americas
  - Most revered of all Virgins in Latin America

Let's continue to explore belief systems and how they impact maternal behavior and attitudes. For example, so much of daily discourse in Spanish-speaking households is full of references to dependence on God (primero Dios, Dios mediante, si Dios quiere, con el favor de Dios, all of which translate to mean God willing) and the Virgin Mary (Virgencita). Therefore, as practitioners it is important to know about who can intercede in times of struggle to help a patient overcome the odds. Above the interaction of the Virgen de Guadalupe and Juan Diego is depicted. Traditionally, Our Lady of Guadalupe is portrayed with darker skin. At her feet, She has an angel and crescent moon. All around Her are glorious rays of sunlight.

Here is the official story from Encyclopedia Britannica:
"According to tradition, Mary appeared to Juan Diego, who was an Aztec convert to Christianity, on December 9 and again on December 12, 1531. She requested that a shrine to her be built on the spot where she appeared, Tepeyac Hill (now in a suburb of Mexico City). The bishop demanded a sign before he would approve construction of a church, however. Mary appeared a second time to Juan Diego and ordered him to collect roses. In a second audience with the bishop, Juan Diego opened his cloak, letting dozens of roses fall to the floor and revealing the image of Mary imprinted on the inside of the cloak—the image that is now venerated in the Basilica de

Guadalupe."

In 1754, Pope Benedict XIV approved her patronage and granted her a proper feast and mass for December 12. Pope Pius X proclaimed her patroness of Latin America in 1910. Pope John Paul II canonized Juan Diego in 2002, making him the first indigenous American saint.

Reference:

Encyclopedia Britannica. (2006). Our Lady of Guadalupe. Patron Saint of Mexico. Available at: https://www.britannica.com/topic/Our-Lady-of-Guadalupe-patron-saint-of-Mexico

Photo taken during ethnographic research trip to México in the Yucatán Peninsula.

Marianismo

- "The Virgin of Guadalupe expresses a Mexican American woman's values of being female, of being a mother, brown-skinned, and mestiza…her image compensates when a Latina feels herself lacking, that she can petition the Virgin for strength, endurance, patience, or compassion" (Rodriguez, 1994).
- Symbolizes the ideal mother based on the Virgin Mary's unconditional love and self-sacrifice

Lets' explore the connection between Our Lady of Guadalupe and womanhood as well as motherhood. "The story, belief, image and cultural memory of Our Lady of Guadalupe helps Mexican Americans to envision a different world.... In this experience, the marginalized have a special relationship with God, one that is especially meaningful for the people who have no other relationship with anything powerful in this world.... For Latinas, the Virgin of Guadalupe provides a spiritual form of resistance.... she is a coping mechanism, a resource.... her image reflects to them who they are ... and gives them a place in a world that negates them" (Rodriguez, 1994).

La Virgen de Guadalupe is a tool for women to make meaning of their perceived reality. She is also a source of empowerment for women and mothers. Marianismo symbolizes the ideal mother based on the Virgin Mary's unconditional love and self-sacrifice. By honoring this socio-cultural expectation of forgiveness and passivity, practitioners can begin to understand the complexity of Mexican women's interactions with themselves and their loved ones, especially their children. Alternatively, practitioners need to understand the positive and negative influence of machismo in health seeking behaviors for recovery. In light of fulfilling the role of protector and provider, a man must be brave and honorable with reserved emotions.

These two constructs are guidelines for behavior that must be taken into consideration. In order to have a sustainable healing relationship and unpack the burden of traditional gender role obligations, practitioners must provide culturally responsive services and constructive psychoeducation that "reduce the vulnerability to negative cognitions and emotions" (Nuñez et al., 2015). Actually, Mexican fathers also play a positive role in birth outcomes, although their effect is generally smaller (Guendelman & Malin, 2001). Studies of Mexican and Mexican American women have documented a positive significant association between male partner support and breastfeeding behavior (Perez-Escamilla 1994 & Scrimshaw, 1987). Additional studies have identified the maternal grandmother and friends of the birth mother as important sources of support for breastfeeding Mexican Americans (Baranowski et al.; Raj & Plitcha; Giugliani et al.)

Following cultural norms is a protective factor even during the prenatal stage. The detrimental impact of substance use during the prenatal period is well documented. Given cultural mores, a Mexican woman strives to model her perinatal health practices in terms of marianismo, the unconditional prioritization of care and nurturance for the greater good based on Mother Mary's standards (Gil & Vazquez, 1996). The adherence to that belief leads her to consume healthier foods and abstain from engaging in unhealthy lifestyles such as alcohol, tobacco, and drugs (Jasso et al, 2002).

Principally because of religiosity and spirituality, Magaña and Clark found that Mexican American women lost fewer babies to all causes during infancy than women of other ethnic groups. However, the question still remains about the specific ways with which these mothers harness the power of faith to actually produce quantifiable positive health outcomes for their infants. Indeed, having a connection with a higher power, praying, and living a moral life dictated by a set of divine rules guides women to behave according to the church's moral compass that celebrates life above all. These guidelines provide instructions that must be followed in order to claim legitimate membership.

Despite variations in religious involvement (degree of adherence creates diverging patterns of sexual behavior, fertility, and possibly even pregnancy outcomes), the act of prayer itself may promote the health of these women and produce a salutary effect on disease (Levin, 1994). Comparatively, Latinas pray for their unborn child more than other women (Levin, 1991).

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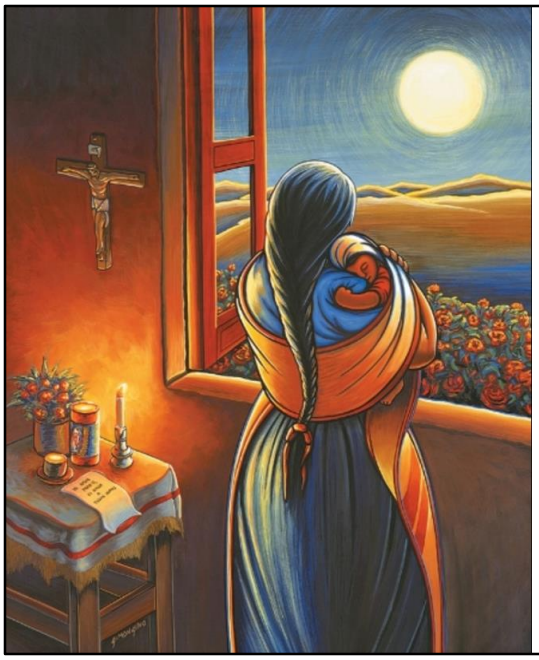
Photo credit: Cornelio Campos



Cuarentena

- "Dar a luz" concept: Bring light forth
- Traditional post-partum recovery behaviors
  - Diet, clothing, bathing, and sexual abstinence as well as specific beliefs/fears about health and expectations of social support
- Observance of a liquid or soft diet.
  - Avoid foods associated with heat, cold, acidity, gas, heaviness, spiciness, or greasiness.
- Favor nutritious drinks, including atoles (cornmeal or oatmeal-based drinks) as well as soups and broths.
  - Traditionally associated with increased milk production
- Significant factor in the establishment of successful breastfeeding practices due to the positive social support from experienced female relatives (Moreland, 2000; Skeel, 1988).

In Spanish, to give birth is to bring light forth. This concept is important to note because it places women in a sacred connection with the divine and therefore their positionality in society changes. Women who have the opportunity or choose to engage in this culturally sanctioned practice are surrounded by support during 40 days of bonding time with their infant. This is a perfect example of how social capital systems interact with the individual during la Cuarentena. This period provides indispensable social support during a time of vulnerability. The social support consists of "extraordinary care, thoughtfulness, assistance with housework and childcare, and individual attention" (Martinez-Schallmoser, 2005, p.331).

According to Waugh, traditionally "families described perceptions of the body as 'open' and vulnerable to drafts or aire." Usually, the body is understood to already be vulnerable under normal conditions, so when a woman is pregnant this signifies that her body is susceptible and at a further risk. After delivery "women reported that the cultural traditions of la cuarentena [forty days of convalescence in the post-partum period that includes abstinence and complete devotion to the child in terms of breastfeeding and attention] will "close" the body, and this was seen as the central purpose of postpartum recovery." In order to follow the birth continuum in the postnatal period, mothers interpret their bodies as changing and in need of

specialized attention, which does not necessarily mean medical interventions, but more like a sacred period to care for themselves and achieve homeostasis by allowing time for their bodies to harness their natural ability to heal and bond with their baby. The fact that their bodies were intellectualized to be 'closed' during the postpartum period and therefore not susceptible to foreign agents reveals the trust allocated to the body's wisdom. These traditions whether fully believed or not by the mother or the medical system, bring a degree of comfort in a time of uncertainty as well as provide a socially sanctioned way of recuperation after labor. If these traditional beliefs are not respected, women may feel isolated and hence reluctant to seek care in a setting where they have to lie because they might be shamed. Therefore, it is imperative for providers to validate and encourage healthful behaviors and attitudes towards la Cuarentana.

To better understand what Waugh refers to with the notions of the body being closed and/or opened, let's unpack the concept of 'aire' further.
Melville (1980, p. 60) analyzed the concept of 'aire, 'which addressed women's perceptions of vulnerability during post-partum recovery. Air currents have been traditionally intellectualized to be dangerous. This is the case especially after delivery. It is believed that:

1. Air can harm the eyes causing "punzadas," which may lead to blindness. It may harm the ears as well.
2. If it is necessary for the mother to leave the house before the prescribed time is over, she must be very careful to cover her head with a cloth that conforms to the shape of the head and thus completely protects it.
3. She must always keep her feet covered, for air can enter through the feet.
4. The shoulders must be covered or a breast infection may develop.

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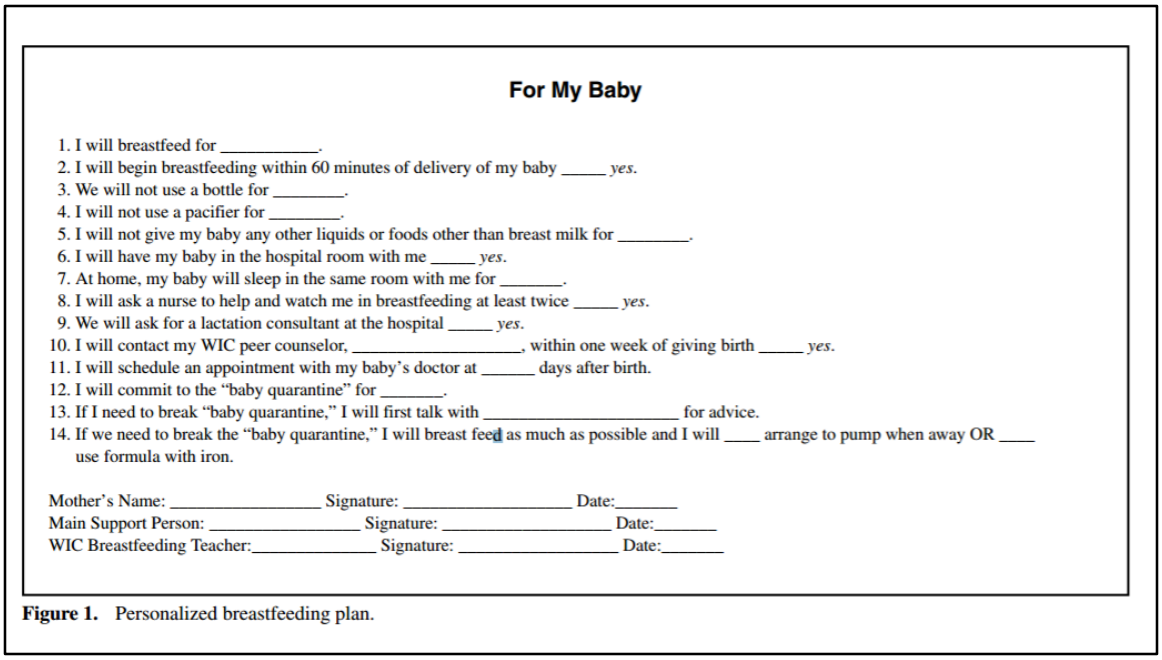
Photo credit: Simón Silva
Titled: “Amor A Todas Horas (Love at all hours)”

Caption: “Watching My Beautiful Wife Take Care Of Our Son, I Realized How Much Work It Takes To Raise A Child. This Is An Homage For All The Mother’s In The World. In Painting This Image I Regained What Was Lost Through Time, Beautiful Memories Of Love All Times! ”

For more information visit: http://www.simonsilva.com/new-page-2-1-1/



For My Baby

1. I will breastfeed for _____.
2. I will begin breastfeeding within 60 minutes of delivery of my baby _____ *yes*.
3. We will not use a bottle for _____.
4. I will not use a pacifier for _____.
5. I will not give my baby any other liquids or foods other than breast milk for _____.
6. I will have my baby in the hospital room with me _____ *yes*.
7. At home, my baby will sleep in the same room with me for _____.
8. I will ask a nurse to help and watch me in breastfeeding at least twice _____ *yes*.
9. We will ask for a lactation consultant at the hospital _____ *yes*.
10. I will contact my WIC peer counselor, _____, within one week of giving birth _____ *yes*.
11. I will schedule an appointment with my baby's doctor at _____ days after birth.
12. I will commit to the "baby quarantine" for _____.
13. If I need to break "baby quarantine," I will first talk with _____ for advice.
14. If we need to break the "baby quarantine," I will breast feed as much as possible and I will ____ arrange to pump when away OR ____ use formula with iron.

Mother's Name: _____ Signature: _____ Date:_____
Main Support Person: _____ Signature: _____ Date:_____
WIC Breastfeeding Teacher:_____ Signature: _____ Date:_____

Figure 1. Personalized breastfeeding plan.

The medical literature extolls that breastfeeding has a ripple effect on the life course of an infant's survival, health, nutrition, growth, cognitive performance, educational achievement, and overall development. Especially for the first six months of life, breastfeeding is the gold standard recommendation that provides all the necessary ingredients that the infant needs as well as fosters healthy attachment through a natural and nurturing bond between mother and child. Breastfeeding is also beneficial for the mother because it helps reduce post-partum hemorrhage, delays the return of fertility and reduces type 2 diabetes as well as the risk of breast, uterine, and ovarian cancers (UNICEF). Further, we also know that exclusive breastfeeding - meaning absolutely no other food or drink other than breast milk - in the hospital is predictive of postpartum breastfeeding patterns.

However, this optimal best practice is challenged by acculturation; the longer Mexican women reside in the US, the less likely they are to engage and sustain breastfeeding. One study found an unfortunate "correlation between acculturation and immediate postpartum breastfeeding, where higher acculturation is associated with lower odds of exclusive breastfeeding" (Gorman et al., 2007). This study reinforces the urgent need for the health system to respect and encourage healthy cultural practices - such as la Cuarentena, which helps establish a pattern of

breastfeeding- that yield better health outcomes in both the short and long terms.

Here is a culturally-relevant solution: la cuarentena del bebé. This intervention was pilot tested in Spanish by a registered dietitian (and the clinic's director) among pregnant Spanish-speaking clients at the Rose Park WIC clinic in Salt Lake City

From the Moreland, 2000 article:

"Traditional teaching of lactation information tends to be didactic and not interactive. This type of teaching model is termed pedagogic. In pedagogic teaching, students learn what the instructors choose to teach and do not decide what they need to learn. This works best in primary education and may not be effective in adult education. In contrast, the andragogic model of learning reportedly works well with adults. The basis of andragogic teaching, according to Knowles**,** is the belief that students learn better if they know why they need to know the material, if the process is self-directed, if their own experiences are brought into the learning, if the subject is relevant to their lives, and if they are internally motivated. The pedagogic model is more likely to widen cultural gaps between students from developing countries and teachers from developed countries, whereas the andragogic model acknowledges the importance of the learner's background."

"The new curriculum focuses on the risk of early supplementation, using a new concept that we named la cuarentena del bebé. This term is based on [the Spanish language] use of the word cuarentena, referring to the 40 days after birth when nothing goes in the woman's vagina; she cannot have sexual relations, use tampons, or douche. La cuarentena del bebé becomes the 40 days after birth when nothing should enter the baby's mouth except the mother's breast. During this cuarentena, mothers should exclusively breastfeed and avoid bottles, pacifiers, and supplementation."

"The class curriculum is designed for interactive discussion of each individual point of the personal feeding plan, "For My Baby." This feeding plan allows mothers to individualize the WHO and AAP guidelines to meet their needs and circumstances, allowing a personal approach to a very personal set of decisions, thus building a bridge between what is recommended and what is actually practiced. Along with providing a personalized education experience, the feeding plan is designed to strengthen a mother's support system and confidence... The feeding plan emphasizes the importance of involving a significant other, choosing a role model to answer questions and resolve concerns, following up early with a physician, and using the resources of WIC peer counseling, lactation consultants, and postpartum nurses."

Following the philosophy of the Latin word "Educare" - to bring out that which lies

within – let's contextually implement interventions that are culturally relevant, bilingual & bicultural, empowering, and evidence-based without shaming and/or blaming moms for their decisions. No mommy wars allowed in the clinic setting!

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Nutrition

- Mexican-origin children are among the heaviest groups in the U.S.
  - After adjusting, 2nd and 3rd generations had greater odds of overweight and obesity (Liu et al., 2012)
    - Consumed less fruit, whole fruit, vegetables, grains, and meats but more sweetened beverages, whole grains, saturated fat, sodium, oil, and energy from discretionary foods.
- Although obesity is also high and increasing in Mexico obesity among U.S.-resident Mexican-origin children does not appear to be imported from Mexico.
  - Instead, Mexican children who are the most likely to migrate to the U.S. are among the leanest in Mexico. They appear to gain weight rapidly after arriving in the U.S..

Ina Mae Gaskin, the mother of midwifery in the US, famously said "gardeners know that you must nourish the soil if you want healthy plants. You must water the plants adequately, especially when seeds are germinating and sprouting, and they should be planted in a nutrient-rich soil. Why should nutrition matter less in the creation of young humans than it does in young plants?"

Now that we have defined Marianismo and its intersection with la Cuarentena, let's look at a specific example of how it affects behaviors. Diet and traditional cooking practices hold a place in the memories of migrants. However, since time is an agent of change, women adapt to maximize their limited resources. In a study conducted to measure the effects of food acculturation, Batis found that "overall, compared to Mexicans, the US subpopulations had greater intakes of saturated fat, sugar, dessert and salty snacks, pizza and French fries, low-fat meat and fish, high-fiber bread, and low-fat milk, as well as decreased intakes of corn tortillas, low-fiber bread, high-fat milk, and Mexican fast food." These patterns held true for all age groups in their nationally representative sample for children ages 2-11 and people 12-49. This trend of low quality and high calorie foods compounded with a sedentary lifestyle have contributed to the obesity epidemic in the US. Unfortunately, in terms of acculturation rates and speed, the study found that "within one generation in the US,

the influence of the Mexican diet is almost lost." The Mexican diet is not an everlasting elixir in the U.S. context; still, if constantly observed, it may be a low-cost strategy that benefits the entire family's wellbeing. Especially, diet plays an important role in preventing and/or controlling gestational diabetes. Therefore, adherence to traditional dietary practices may reduce the incidence of gestational diabetes in the short term and prevent obesity in the long term.

In a study by Liu (2012) "after adjusting for socio-demographic factors, health, dietary intake, physical activity, and sedentary behaviors compared to the first generation, second and third generations had greater odds of overweight and obesity. Both second and third generation adolescents consumed less fruit, whole fruit, vegetables, grains, and meats but more sweetened beverages, whole grains, saturated fat, sodium, oil, and energy from discretionary foods. Higher language acculturation was associated with poorer diet and greater body weight."

Van Hook et al. (2016), reveal that "Mexican-origin children are among the heaviest race/ethnic groups in the U.S. (Flegal et al. 2010; Ogden et al. 2012). Although obesity is also high and increasing in Mexico (Rivera et al. 2009), obesity among U.S.-resident Mexican-origin children does not appear to be imported from Mexico. Instead, Mexican children who are the most likely to migrate to the U.S. are among the leanest in Mexico. They appear to gain weight rapidly after arriving in the U.S. (Van Hook et al. 2012)." This is worrisome because as we have learned before, thanks to life course theory, children's eating behaviors will affect their health and well-being across throughout their life time (Birch 1999; Birch and Fischer 1998). "Dietary acculturation is a general process of dietary change that often occurs among immigrants. One important aspect of dietary acculturation involves the shift from a diet consisting primarily of foods eaten in the immigrants' country of origin to those of the host society (Satia-Abouta et al. 2002). Research has suggested that "migration to the U.S. and duration of residence are associated with consuming fewer vegetables, less fiber, more meat, fat, and sugar (Akresh 2007; Ayala et al. 2008; Batis et al. 2011; Brown 2005; Dixon et al. 2000; Duffey et al. 2008; Guendelman and Abrams 1995). Children of natives consumed more Americanized, unhealthy diets than children of immigrants and these differences were largely explained by differences in the acculturation. Overall, the results suggest that the process of adapting to the U.S. life style is associated with the loss of cultural culinary preferences and less healthy eating behaviors despite improvements in socioeconomic status (Van hook, 2016)."

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Photo credit: Simón Silva
Titled: “Breast Feeding”
Caption: “Sacred Moments Where A Different Language Is Spoken.”

Motivational Interviewing

- Care team interface mission is to protect healthy behavior
  - By evoking instead of prescribing
- Relevant questions: Think back to your time at home, what were the staples? What did your caregivers recommend?
- What do you know about nutrition?
- What would you like to know about nutrition?
- How do these recommendations apply to you?
- What do you think is the next step for you?
- Find hope!
- Use an importance ruler
  - How important is it for you to _____?

A useful tool for prevention is motivational interviewing (MI). MI is a goal-oriented collaborative conversation style for strengthening motivation and commitment by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. MI is a person-centered counseling style. MI is done "for" or "with" someone, not "on" or "to" them. As practitioners you should try to evoke what is already present and therefore empowering due to the virtue of its embeddedness. MI is an evidence-based golden standard of practice for the dietary and nutrition professions. Additionally, MI is also used in counseling as a tool to evoke change talk especially when there is ambivalence.

Here is a brief introduction to the practice based on its creators' book (Rollnick and Miller):

-Elicit-provide-elicit is a sequence for information exchange that honors the client's expertise and autonomy (pg 153)
-Regarding advice: engage first, use sparingly, emphasize personal choice, and offer a menu of options (pg 153)

Focus on Reasons questions pg 172

Reason questions ask for specific reasons why. They explore if…then reasons for considering or making a change

1. What's the downside of how things are now?
2. What would make it worth your while to_____?
3. What could be some advantages of_____?
4. Finish the sentence: 'Things can't go on the way they have been because…"
5. What might be the 3 best reasons for___

DO NOT ASK pg 173

1. Why haven't you changed?
2. What keeps you doing this?
3. What were you thinking when you messed up?
4. Why aren't you trying harder?
5. What is the matter with you?
6. What is wrong with you?
7. Why can't you_____

Chapter 16: Find Hope: pages 212- 230

"Finding hope is a matter of calling forth that which is already there. The working assumption is that the client has wisdom, insight and creativity to be tapped."

-Find hope by reviewing past successes:

1. What changes have you made in your life that were difficult to you?
2. What things have you managed to do that you weren't really sure at first you would be able to do??
3. How did you do that? What worked?

*Remember you want the patient to be making arguments of confidence

-Find hope by hypothetical thinking

1. Suppose you did succeed, and were looking back on it now. What most likely is it that worked? How did it happen?

Ask about perceived need (importance rather than readiness). Page 174

"On a scale from 0 to 10, where 0 means 'not important at all' and 10 means 'the most important thing for me right now,' how important would you say it is for you to….."

Then follow up with "and why are you at a ____ and not 0 (or a lower number)?

This will evoke change talk or the reasons why change is important.

Someone can answer 0, which would signal no ambivalence at all and would provide an opportunity to explore other interventions.

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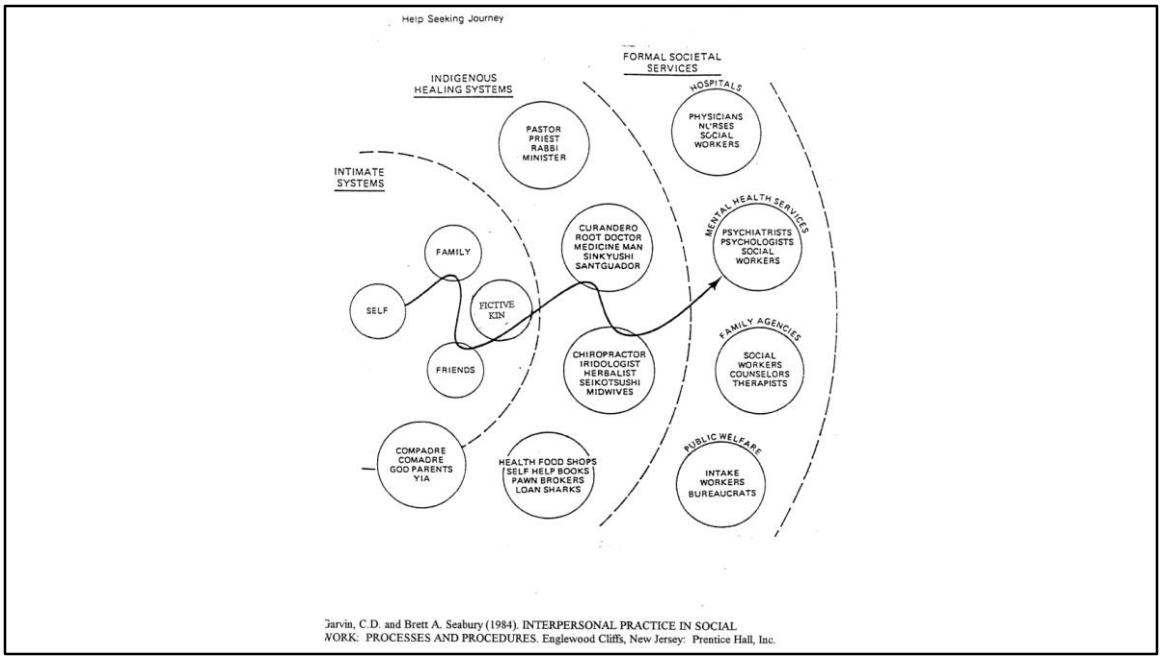
Photo credit: Diego Huerta



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After considering the aspects of motivations to change, let's look at the motivations and stages of care seeking. Here is a model of the health seeking journey. As practitioners, we must be aware and respectful of client's resistance, tolerance, or adoption of practices including behaviors and attitudes. Especially, given the fact that the help seeking journey has a hierarchical path from intimate systems to indigenous healing systems to formal societal services.

In fact, Kleinman (1980) suggested that the majority of health care takes place within families through the application of home remedies. In context, the longer Latinx immigrants live in the US, "the more likely they are to use complementary and alternative medicines because of deteriorating health, lack of access to care, or unsatisfactory interactions with the medical system" (Su and Li, 2011; Su et al., 2008).

Within the family unit, Kay (1977, p.101) explains how Mexican American women have the control. "The Mexican American woman believes that much illness is due to the way one lives. She has explicit ideas about what kinds of activity, recreation, and nourishment lead to good or poor health. As the regulator of diet and preparer of food, she is almost solely responsible for nutrition of family members, when she thinks that someone is sick, she tries to discern what the illness might be and what

care would restore health or at least give comfort. For it is the woman in the Mexican American family who will determine what should be done."

From Waldstein, 2010:
"The popular sector is both the oldest and most central part of any health care system…folk and popular medical traditions remained widespread throughout Mexico's history and are still the most important sources of medical care in most Mexican communities (Berlin and Berlin 1996; Browner 1985; Frei et al. 1998; Leyva-Flores, Kageyama, and Erviti-Erice 2001). Mexico's heritage of indigenous cultures has made it a nation with a complex cultural wealth of traditional medical systems (Lozoya 1994). Cultural and biological diversity form the basis of popular medicine that helps support the health of the nation, largely through the use of more than 5,000 medicinal plant species (Frei et al. 1998). During the colonial era in Mexico, missionaries, rather than doctors, were primarily responsible for the care of the sick (Kay 1977b). While many indigenous cosmological beliefs about health and sickness were lost or transformed by Spanish missionary activity, the empirical use of medicinal plants by folk specialists and the general populace remained vibrant. The Spanish were greatly interested in the medicinal plants of the New World and incorporated many Aztec plants into colonial medicine because they fit European conceptions of illness and the Hippocratic-Galenic doctrine of balancing humors (Ortiz de Montellano 1990)…Self-care with medicinal plant remedies has maintained continuous popularity in Mexico for a variety of reasons. Biomedical clinics were slow to spread through rural Mexico, many people cannot afford professional biomedical care (Leyva-Flores et al. 2001), and, as my research participants suggest, medicinal plant remedies are considered safer and/or more effective than pharmaceutical medicines. Although medicinal plant use and other self-care practices have evolved since the colonial era, they never fell into disuse." This historical account of the merging and converging of healing systems is important to understand, especially when we ask a patient "what are they taking?" besides vitamins. Practitioners must consider asking about herbs and teas.

Lopez (2005) explains that "the melding of Spanish and Aztec scientific and religious beliefs added to the scientific rationality perspective a supernatural element incorporating metaphysical connections to a spiritual world with the power to cure, as well as the power to impose illness. It is a perspective that recognizes psychosocial contributors to illness and to health. Niska and Snyder surveyed young, Mexican American parents who described health as " ... more than freedom from illness" (p. 229). Their perception of optimal health was expanded to include the "physical, emotional, social interactional, and spiritual integration of their ... family" (p. 229). From this broader perspective of health dynamics, modern medicine omits potential contributors to illness as they seek to diagnose the causes of illness in some Mexican American patients through strict scientific, intellectual investigation. Folk medicine

provides a broader perspective which takes into account the cultural significance and the personal and social meanings of illness. Krajewski-Jaime outlined three central aspects of folk medicine among Hispanics: first, the role of the kin in diagnosing and treating illness; second, the connection between religion and illness which fostered the use of religious ritual in healing practices; and third, the universality of many health beliefs, symptoms, and regimens of healing among Latinx communities (p. 161)."

"Prevailing, formal health care systems are encouraged to recognize the folk belief systems and practitioners as opportunities to enhance outreach to ethnic enclaves. Magana and Clark among many, stress the inadequacy of narrow health care paradigms which exclude indigenous and culturally responsive health belief systems which persist among immigrant populations. Rather than fearing or shunning folk practitioners, today's formal medical establishment should engage in collaborative activities of health education and preventive services. The gatekeeper role that informal folk practitioners can play in reaching otherwise disengaged needy may be underestimated and underutilized. With the vagaries of economic systems disallowing medical coverage and with anti-immigrant public initiatives reducing health care benefits and programs for one segment of the Mexican American population, this topic should be of concern. If, in fact, the mutual goal of both folk and establishment health care personnel is the enhanced health and functioning of the Latinx patient, then a reciprocal understanding of the strengths of each system would ultimately benefit many seeking effective health care" (Lopez, 2005). Here is a call to action to integrate healing systems and adopt a multi-disciplinary team approach given the Hippocratic Oath and the bioethical framework of beneficence, justice, non-maleficence, and autonomy.

In Sherraden and Barrera's (1997) qualitative study using ethnographic methods, they found that "a major difference between everyday pregnancy care and medical prenatal care is the mode of delivery, rather than the content of care." There is overlap and agreement in content of care especially of preventive care such as emphasis on nutrition, avoiding hazardous substances, reducing stress, and getting regular exercise. This consistent health messaging from two key sources: the social support network and the medical providers is an opportunity for using what already happens at home to reinforce medical care. Bottom line, it is an issue of framing, validating, and reinforcement through "structur[ing] the delivery of medical care so that it complements every day care." For example, practitioners should support the family's role in pregnancy whenever those dynamics are healthy. Additionally practitioners should affirm the every day practices that are healthy and redirect when those practices are not useful (use and/both not either/or).

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Curanderismo

- Traditional Mexican medicine focused on healing
- System of knowledge, beliefs and practices
  - Intent on the prevention and treatment of illnesses or the management of causes of misbalance

Table 2. Classification of *Curandero/as*

Specialty	English Translation	Description
Yerbero/a	Herbalist	Uses herbs to bring about healing
Sobador/a	Masseuse	Treats sore muscles, sprains, tension, etc.
Espiritualisto/a	Psychic medium	Utilizes talking with or possession by spirits to bring about healing
Señor/a	Tarot card reader	Uses tarot cards to predict future and advise
Partera	Midwife	Assists in the delivery of a child

Now, let's explore one system of care. "Curanderismo is an integral part of Mexican-American culture, encompassing religious, spiritual, and health-related beliefs and rituals. This indigenous healing practice invokes feelings of faith, hope, confidence, and happiness for some and of fear, distrust, embarrassment, and confusion for others" (Zacharias, 2006).

Above, Salazar & Levin (2013) provide a useful classification of practitioners.

According to Zacharias (2006) "traditional Mexican medicine is known colloquially as Curanderismo, a word with its literal origins in the Spanish "curar", which means "to heal". Its practitioners are the curanderas and curanderos. Mexican traditional medicine has been defined as a "system of knowledge, beliefs and practices which are intent on the prevention and treatment of illnesses or the management of causes of misbalance, which is perceived as pathological for the individual or the social group" (Instituto Nacional Indigenista/Sectretarìa de salubridad y Asistencia, 1993, p. 45)—a system with roots in precolonial Indian, European, and, to a lesser degree, African heritages. The traditional medical system of Curanderismo is not unique to Mexico but can be found in very similar forms in Middle and South American countries due to the common historical background and the powerful influence of

Indian cultures in those regions."

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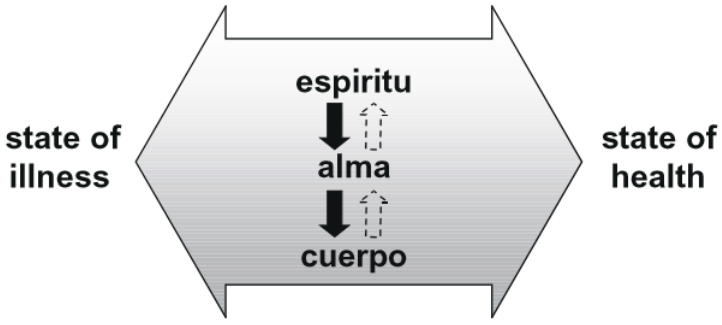

Figure 1. The Mexian *curanderos*' concept of health and illness

Let's look at the conceptualization of health by curanderos. Zacharias (2006) explains that "Mexican curanderos understand health and illness as a manifestation of an interactive process between three main dimensions of regulatory processes; the religious and/or spiritual dimension, the affective-emotional dimension, and the somatic processes of health and illness. This multidimensionality is expressed via the three concepts of "spirit" (espíritu), "soul" (alma), and "body" (cuerpo). The three levels are connected by interactive processes that represent a hierarchical schema."

"The properly functioning espíritu of a person is described by the healers as a "guardian" of mental and somatic health. If the espíritu is not able to fulfil its protective function because of absence or weakness, the lower level of psychic regulation—the alma—is affected. The most frequent types of dysfunction or distortion of the alma that the healers mentioned were the excess of emotions felt by individuals such as an intense, pathological feelings of envy or rage, or an overwhelming sadness. Functionally, these emotional processes are clearly subordinate to the mental processes regulating the dimension of spirituality, religion, and consciousness."

As western allopathic health practitioners, we must understand the importance of

integrating health belief systems in order to ensure quality of care. We must also understand that these beliefs exist and dictate the behavior and attitudes of our patients. Bottom line, you don't have to agree, practice, or condone behavior. However, you must respect beliefs, values, and practices instead of condemning or mocking them. For example, if you are curious then ask in a culturally sensitive and humble way. By being non-judgmental, you can continue building on that healing partnership. This way you gain privileged access to all the relevant information in order to get to a diagnosis of the root cause of the problem, which will hopefully lead to an alleviation of the symptoms.

Reference:

Zacharias, S. (2006). Mexican Curanderismo as Ethnopsychotherapy: A qualitative study on treatment practices, effectiveness, and mechanisms of change. *International Journal Of Disability, Development & Education*, *53*(4), 381-400. doi:10.1080/10349120601008522

Culturally-bound illnesses

- Empachado
- Colera
- Susto
- Mal de Ojo
- Nervios
- Mal de Aire
- Bilis

It is important to recognize some culturally-bound illnesses that apply especially to the transition from womanhood to motherhood. In Trotter's study of the Lower Rio Grande Valley, he identified susto, empacho, keeping evil spirits away, mal de ojo, and caida de mollera as supernatural in nature and without an English biomedical equivalent. He warns not to over or under emphasize the existence and importance of these health events.

Empachado: bloated. Test for appendicitis though!
Colera: fury/anger. Do not confuse with the water-borne bacterial illness.
Susto: magical fright or soul loss
Mal de ojo: evil eye= evil eye is the belief that if you admire a child by looking without actually touching him or her, the child can become very ill.
Caida de mollera: fallen fontanel—believed to be the result of rough play or abrupt removal from breast. Check for dehydration though!
Mal de aire: negative air/ bad vibes
Bilis: acid formed in the stomach resulting from anger

There are specific culturally-sanctioned idioms that express distress regardless of gender. For example, Paniagua (2002) described a common cultural-bound syndrome

such as ‘colera,’ the symptoms of which include anger and rage that disturb an individual’s body balances “leading to headache, screaming, stomach pain, loss of consciousness, and fatigue.” Another example is ‘ataque de nervios,’ which means a “demonstration of strong emotions due to stressful life events” that looks like “shouting, swearing, and striking out at other, and falling to the ground.” It is common that ‘susto’ which is “a prolonged and chronic condition-similar to depression-described as having lost one’s soul due to a traumatic event” is part of the expected sequelae.

Trotter (1981) listed specific ailments exclusively suffered by women as “dolor del aire, chills, babies' diarrhea, bad luck, deformities, bed wetting, nose bleeds, sprained joints, ringworms, dandruff, pano (dark spots on the skin), dry irritated skin, measles, loss of appetite, to gain weight, anxiety, face problems (spots, rough skin), help closing navel on newborns, and to clean the uterus.” Additionally, other female issues regarding pregnancy were “infertile womb, along with morning sickness, vaginal douches, and yeast infections.” Further, Trotter identified that no males reported keeping away evil spirits as a problem, which alludes to the greater role women play in acknowledging supernatural occurrences and petitioning for protection and divine intervention when a challenge arises. Whether evil spirits or health insults are at stake, the precautionary principle always rules. When in doubt, mothers traditionally rely on socio-culturally-sanctioned mechanisms for healing. For example, religion, spirituality, traditional healers, and rituals are common solutions.

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Photo credit: Diego Huerta

Meta-communicate

- Do not assume
- Do not take anything personally
- Avoid use of jargon
- Use cultural mediators
- False cognates
  - Embarazada
  - Intoxicado
  - Excitado
  - Crudo

Here are some strategies for capacity building in the area of communication.

First, let's be aware if false cognates.
Embarasada: means pregnant, not embarrassed
Intoxicado: All encompassing word that means there's something wrong with you because of something you ate or drank
Excitado: sexually aroused
Crudo: raw/ drunk or hung over

It is well established that language barriers are associated with "poor quality of care in emergency departments (EDs); inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors" (Brach, 2005). Most importantly the study found that "compared with proficient English speakers, people with limited English proficiency (LEP) are less likely to seek care and to receive needed services when they do. They have fewer physician visits and receive fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators, or ethnicity are controlled for. Language barriers are associated with poor quality of care in emergency departments (EDs); inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors. Patients with language barriers have lower satisfaction with care, even when compared with patients of the same ethnicity who have good English skills."

So above all, be mindful of setting up appointments by phone, follow-up, and delivery of results.

The solution to this problem starts with not assuming, not taking anything personally, avoiding the use of jargon, and having a multi-disciplinary team. In order to meta-communicate, the practitioner must pay attention to the underlying messages in what is said and done. In general, meta communication is understood as the non-verbal cues (body language, tone of voice, gestures, facial expression).

Cultural mediators who in addition to medical interpreting also facilitate understanding of the "cultural and social circumstances that may affect care" are useful when trying to overcome language and cultural barriers. Especially because "physical symptoms of stressors often labeled somatic complaints may not have the same cultural meaning as the medical model and DSM-V pathology" (Villarruel et al., 1998). Villarruel et al. proposes this intervention given that it "enables providers to gain a more comprehensive understanding of patients needs, and to negotiate culturally appropriate plans of care." This is a strategy for building rapport and fostering trust at the same time as improving health outcomes and patient satisfaction.

Cultural mediators are a great tool to meet the HRSA call to action "as health care providers we should appreciate the key role culture plays in our ability to influence behavior in a patient population. We cannot afford to let cultural barriers limit our ability to meet the needs of our patients, or reduce their opportunity to benefit from the services we can provide" (HRSA). Their handbook for cultural competency explains how practitioners should deliver care when faced with cultural nuances, miscommunications, misinterpretations, and misunderstandings due to language, place, and culture.

Remember that it is a HIPAA violation to use patient's relatives, especially those who are younger or neighbors/friends for interpretation services. Using a minor may be traumatic and taboo, whereas using a friend may lead to chisme (gossip) or lack of confidentiality and privacy. Do not use janitorial staff, it is embarrassing and conflict of interests may arise. Remember that some people may comply with a request from an authority figure even when they not fully being competent to translate and/or interpret. People may do this for a variety of reasons, especially to please, maintain their job/position, make the process faster, easier, etc.. So, let's not put people in a double-bind because everybody loses. There are professional interpreters who can help, rely on them always!

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Photo credit: Diego Huerta

Consequences of LEP

- Mexican migrant women
  - Less likely to have medical supervision
  - More likely to self-medicate
- Speaking a language other than English at home (Cheng)
  - At risk for **not** receiving recommended health care services, whether they were comfortable in speaking English or not
- Language barrier premiums
  - "No voy al doctor hasta que me esté muriendo" = until it is too late→more ER visits

Let's take a deeper look at the consequences of having Limited English Proficiency.

The maintenance and expansion of the health paradox can only happen when women have access to health clinics that budget for a sliding scale of prices, bilingual referrals, and shorter bureaucratic intake processes. Unfortunately since "Mexican migrant women are less likely to have medical supervision and more likely to self-medicate" they confront a bigger challenge in terms of prevention in allopathic ideology (National Population Council, 2010).

It is unfortunate that regardless of level of comfort of speaking English, "speaking a language other than English at home identified Hispanics at risk for not receiving recommended health care services" (Cheng, 2007).

Language barrier premiums stem from two sources. First, "LEP patients have more diagnostic tests, presumably because of physicians' attempts to compensate for communication difficulties." Resource utilization increased because physicians were more cautious in the absence of a bilingual physician or professional interpreter/cultural mediator (Hampers, 2002). Second, "LEP patients are more likely to be admitted to the hospital from the ED" (Lee, 1998).

The quality of communication during the history-taking segment of the visit and the discussion of the management plan influence patient health outcomes. Specifically, the outcomes affected were “emotional health, symptoms resolution, function, physiologic measures (blood pressure and blood sugar level) and pain control.” This study clearly reinforced the association between effective physician-patient communication and improved health outcomes (Stewart, 1995). Just another justification to practice patient-centered care!

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Photo credit: Diego Huerta

Title VI of the Civil Rights Act of 1964

- Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons.
- Definition
  - Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.
  - Need to be aware that he or she has the option of having the recipient provide an interpreter for him/her **without charge.**
  - Recipients cannot require LEP persons to use family members or friends as interpreters.

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance (such as Medicare, Medicaid, and HillBurton funds)."

This is just a reminder of the legal definition and compliance information regarding interpreters for any recipient of U.S. Department of Health and Human Services assistance.

Just to further understand the need for linguistic competence and cultural mediators, "Mexico currently encompasses 364 indigenous dialects, belonging to 68 distinct languages which branch off from 11 language families (INEGI, 2015)."

The National Council on Interpreting published a document with standards of practice for interpreters in health care. The document provides the following guidelines regarding skills and tasks for interpreters: "accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development, and advocacy."

For more information, visit:
http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf

References:

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Photo credit: Diego Huerta

Module 3:
Sustainability & Lessons Learned

“You are a midwife, assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say, "We did it ourselves!”- Tao Te Ching

This module is about actively implementing and improving on what works. The formula for applied implementation is effective intervention X effective implementation X enabling contexts = socially significant outcomes (Fixen et al, 2005). If any of these components is missing, then programs will not work optimally. Remember that anything multiplied by zero is zero.

The outline is as follows:

Sustainability
Human Rights
ROI
Preconception Health
Show Your Love

Doula

Reference:

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Photo Credit: Cornelio Campos

Sustainability

- Responsibility because we already have good health outcomes:
  - Call to action: Let's at least sustain them
  - Hope: Collectively and synergistically join forces to improve them
  - Opportunity to scale up
- Stewardship
- Sustainability is seen as "what we leave to future generations; whether we leave enough resources, of all kinds, to provide them with the opportunities at least as large as the ones we have had ourselves" (Veiga, 2010).

Throughout this whole training curriculum, the philosophy that prevention is better than reaction and that we must learn the from the strengths displayed in a historically marginalized population has been a pattern. Currently, interventions are reactionary rather than preventive because there is not a profound understanding of the problem given the lack of in-depth analysis of the institutional systems that are causing them. The lack of strength-based approaches to address health disparities and health inequities is a result of the modus operandi of looking for downstream solutions to symptoms rather that upstream solutions to causal problems.

This curriculum has been a call to action to proactively do 3 things in terms of stewardship:
1. Sustain progress
2. Improve on the healthy birth outcomes already displayed in the children of Mexican Migrant Women
3. Contextually scale up to other populations in need

The belief in sustainability is intimately related to the socio-cultural mechanisms that enable the health paradox. For example, social capital is paramount because divided communities do not develop. Therefore, we must go from bonding like groups to

bridging across groups and finding common ground for all to prosper.

In order to be truly successful in maintaining and improving birth outcomes and health throughout the life course, the concept of dynamic sustainability is helpful.

The Dynamic Sustainability Framework "involves continued learning and problem solving, ongoing adaptation of interventions with a primary focus on fit between interventions and multi-level contexts, and expectations for ongoing improvement as opposed to diminishing outcomes over time" (Chambers et al., 2013).
First, the authors define sustainability as "to what extent an evidence-based intervention can deliver its intended benefits over an extended period of time after expectant support from the donor agency is terminated."

Here are the 7 tenets of the Dynamic Sustainability Framework:

1. "An intervention should not be optimized prior to implementation, or even prior to 'sustainability phase' onset.
2. "Interventions can be continually improved, boosting sustainment (the continued use of an intervention within practice) in practice, and can enable ongoing learning among developers, interventionists, researchers, and patients."
3. "Ongoing feedback on interventions should use practical relevant measures of progress and relevance."
4. "Voltage drop is NOT inevitable"
5. "Programs should be more likely to be maintained when there is strong 'fit' between the program and the implementation setting."
6. "Organizational learning should be a core value of the implementation setting."
7. "Ongoing stakeholder involvement throughout should lead to better sustainability."

The Dynamic Sustainability Framework can help "to reconfigure the research-practice-policy interface, in which the best possible information is gathered and used in real time to inform policy, improve practice, and answer the highest priority research questions" (Chamber et al., 2013).

In the context of this curriculum, what is the life expectancy of the structurally competent and patient-centered tools that you just learned? Also, what is your degree of optimization of those tools? Are the tools relevant to your practice? Are the tools feasible given your scope of work? Are you ready to implement them ("the process of putting to use or integrating evidence-based interventions within a setting")? These are questions worth considering as you move onwards and forwards.

References:

Veiga, José Eli da. (2010). Indicadores de sustentabilidade. *Estudos Avançados*, *24*(68), 39-52. https://dx.doi.org/10.1590/S0103-40142010000100006

Chambers DA, Glasgow RE, Stange KC. The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science*. 2013;8:117-117.

Photo credit: Cornelio Campos

Human Rights

- WHO: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
  - “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition”
    - “Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”
- UN: “Motherhood and childhood are entitled to special care and assistance”

Our responsibility as health care providers in terms of dynamic sustainability revolves around the notion that health is a human right.

The standard definition of health created by the World Health Organization is integrated in nature and interdependent in scope: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition has not been amended since 1948, demonstrating its caliber for encompassing a complex subject. Further, the preamble to the WHO Constitution describes that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition” and that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”

Indeed, the conceptualization of human rights is just as hopeful, ambitious, and complex as the idea of health. The preamble to the Universal Declaration of Human Rights proposes that human rights and dignity are self-evident, the “highest aspiration of the common people,” and “the foundation of freedom, justice, and peace.”

There are three fully recognized parts that can guide institutional understanding for implementation and evaluation of health as a human right intervention.

The first part involves an optimal balance between promoting and protecting public health and doing the same for human rights. In order for this to happen, institutions should “verify that their national health policies, plans, and laws follow current national and international human rights instruments” (Virtual Campus for Public Health). The second part of this relationship is that “violations or lack of fulfillment of any and all human rights have negative effects on physical, mental, and social well-being” regardless of context of peace time or war time. The final part of the health and human rights relationship is that they operate synergistically and symbiotically because the “enjoyment of health is necessary for exercising human rights; and at the same time, exercising human rights positively contributes to the enjoyment of health.” Unfortunately, the concept of exercising human rights and enjoying health is not distributed proportionally in the US due to the social injustices that vulnerable populations endure. Recognizing this disparity of disenfranchised members of society, the Universal Declaration of Human Rights (1948) states that, “motherhood and children are entitled to special care and assistance.” This protection should be a wake-up call to respect, protect, and fulfill the health as a human right ideal.

Now, we must go from a idealistic statement to an actual enforceable commitment in order to ensure sustainability and accountability in both the micro and macro settings.

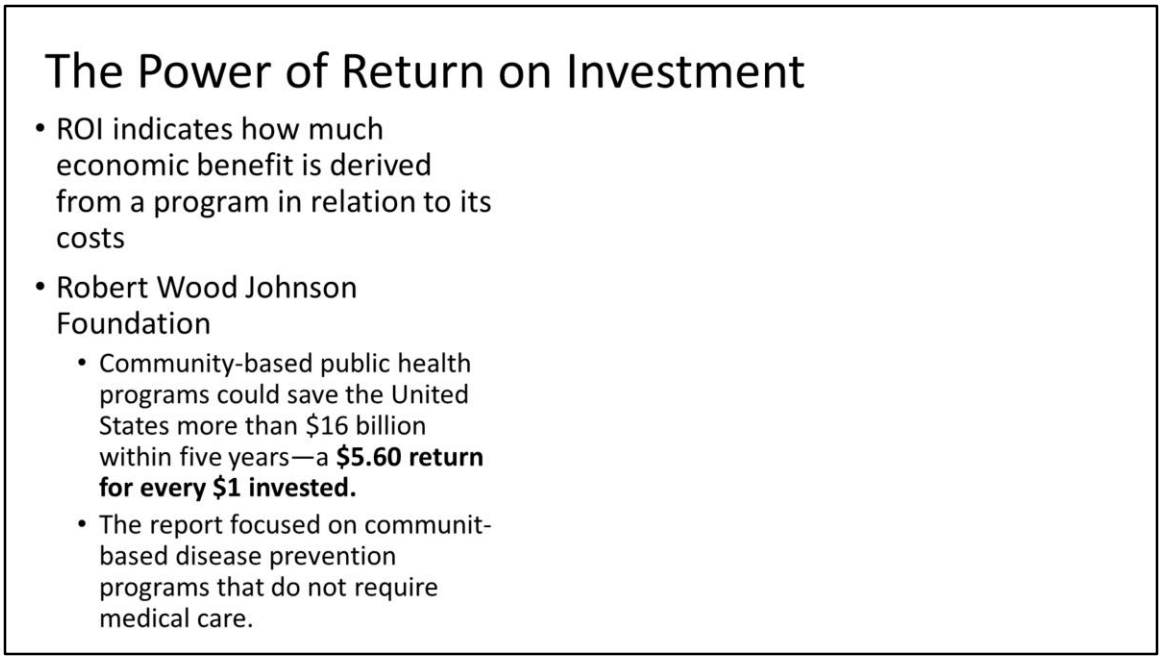
References:

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

UN General Assembly, 1948. Article 25 of The United Nations Declaration of Human Rights.

Virtual Campus for Public Health. PAHO/WHO. Basic E-Learning Course on Human Rights and Health. Prof. Esmeralda Luz Urbano Jaramillo.

Photo credit: Cornelio Campos



The WHO defines a health care system as "all the activities whose primary purpose is to promote, restore, or maintain health" (WHO, 2000). This ideal does not guarantee that all of its working spheres are cohesively integrated nor synergistic. For example, the U.S. has a fragmented system that spends more money than other high income nations without meeting the indicators of healthy life: mortality amenable to medical care, infant mortality, and healthy life expectancy at age 60 (The Commonwealth Fund, 2015). Actually, the US's health care system is the most expensive in the world, least efficient, and least equitable (Davis et al, 2014). Until the US health system implements evidence-based best practices such as combining vertical and horizontal approaches to health care delivery, then individual health will thrive (Mills, 2005). Then, we will see a return on investment and overcome being 37th in overall health system performance (Murray, 2010).

We know that "community-based public health programs could save the United States more than $16 billion within five years, which is $5.60 return for every $1 invested" (Robert Wood Johnson Foundation, 2013). However, by not actualizing half the population's potential by virtue of denying health as a human right at the individual level, the country as a whole lacks the advantage of productivity, effectivity, or efficiency, let alone being able to compete in the world market. This reality

translates as an intergenerational opportunity lost, an issue that is completely preventable.

The video provided above by the American Public Health Association is an example of the power of ROI.

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World Health Organization. (2000). Why do Health Systems Matter? WHO Report. Available at: http://www.who.int/whr/2000/en/whr00_ch1_en.pdf

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Murray CJL, Frenk J. Ranking 37th — Measuring the Performance of the U.S. Health Care System. The New England Journal of Medicine. 2010; 362:98-99.

Robert Wood Johnson Foundation. (2013) Return on Investments in Public Health: Saving Lives and Money. Policy Highlight Brief. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf72446

American Public Health Association https://www.youtube.com/watch?v=B5M9JefYxJI

- Heckman Equation
  - Invest + Develop + Sustain = Gain
    - Invest: Educational and developmental resources in order to provide equal access to successful early human development
    - Develop: Nurture early development of cognitive and social skills in children from birth to age 5
    - Sustain: early development with effective education through adulthood
    - Gain: more capable, productive, and valuable workforce that pays dividends in the long-term

Another way of understanding the need for investment in prevention is with a concept developed by Dr. James Heckman, a Nobel Laureate and Prof. of Economics at the University of Chicago whose expertise is in the economics of human development. He believes in the 'urgency of now' and realizing our potential without squandering resources. He believes in evidence based investments since early childhood because human potential is realized to its maximum by giving people access to those resources since the beginning. According to his calculations, early childhood investments have a 10% rate of return, which is how much you get back per annum for each dollar you spend. By further investing in early growth and development, we as a society could synergistically increase productivity by giving people the capacity to function self-sufficiently and meet life's challenges through self-efficacy as well as reduce inequality and inequity by providing a healthy start and evening out the playing field.

For more information, visit: http://heckmanequation.org/heckman-equation

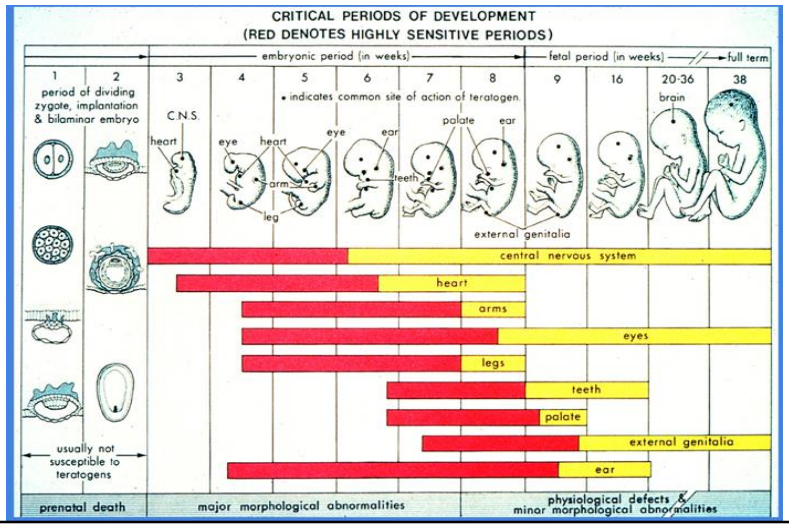
Reference:

Heckman JJ, Moon SH, Pinto R, Savelyev PA, Yavitz A. The rate of return to the

HighScope Perry Preschool Program. *Journal of Public Economics*. 2010;94:114-128.

Photo credit: Simón Silva
Piece named: Amor de Padre
Captioned: “A Homage For All Our Fathers Whom By Working A Job That Very Few Want To Do, Show Us That They Love Us. A Father’s Love Can Come In Many Ways That Go Unnoticed And Un Appreciated”

Preconception Health



To take it one step further, if we are already going to start focusing on early prevention, why not since the very beginning?

Preconception health is defined as a "set of interventions that aim to identify and modify biomedical, behavioral and social risks to a woman's health or pregnancy outcome through prevention and management." Through iteration and consensus, the CDC and their select panel for the Preconception Health and Health Care Initiative agreed that preconception health was more than reproductive health because "achieving a high level of wellness [should be] irrespective of whether women hope or plan to become pregnant." This means preconception health is really a women's health issue, regardless of reproductive plans and choices because women's health in and of itself should be prioritized unrelated to their capabilities of reproduction and/or her intention of bringing life forth. Thus far, preconception health status and risks before pregnancy extend to men as well. This is a very heteronormative conception of what a family looks like today though. Therefore, it is necessary to expand the scope of responsibility for the provision of non-judgmental quality health care services for the LGBT+ community.

For example, there are critical events in development before prenatal care begins

that must be taken into consideration. Biologically speaking, placental implantation begins 5 days after fertilization has occurred. Implantation is complete by days 9-10. Actually, days 17-56 after fertilization represent the most critical period for development of structural anomalies. The formation of organs (organogenesis) begins just 3 days after the first missed menses. All of this happens before most women know they are pregnant and have access to health care. This timing is even more important of the disparities in health care utilization already discussed. Moreover, women in general may even confuse the early symptoms of pregnancy with the symptoms associated before and during menstruation, and therefore be less likely to recognize pregnancy. Some of the symptoms associated with early pregnancy are spotting and cramping (implantation bleeding), breast changes, fatigue, nausea, frequent urination, constipation, mood swings, headaches, back pain, dizziness and fainting.

Given this reproductive health science and basic common sense, it is logical to deduce that women who are healthier at baseline have healthier reproductive outcomes. This rationale provides proof and a sense of urgency to meet preconception health needs with the health as a human right intervention for Mexican migrant women who are at a higher risk of losing their outcomes with acculturation and time.

References:

Before, Between, and Beyond Pregnancy. The National Preconception curriculum and resources guide for clinicians. Continuing Education Modules. Power Point Presentation: Module 1- Preconception Care: What it is and what it isn't. Available at http://beforeandbeyond.org/modules/

National Population Council of the Government of Mexico and the University of California. (2010). Migration & health: Mexican immigrant women in the U.S. Mexico, D.F.: Consejo Nacional de Población.

Show Your Love App

Are you ready to get pregnant? If so, it's time to nurture and love yourself by planning and preparing your body for pregnancy. Follow some simple steps with this app to improve your preconception health. - Brought to you by CDC Foundation and Anthem.

Available on: Android and iOS

Above is the logo for the brand new and free App by the CDC Foundation and Anthem. Download it and follow some simple steps to improve your preconception health today. It is never too early nor too late to take care!

The Preconception Health and Health Care (PCHHC) is a national public-private partnership created in 2006. Their raison d'etre came after realizing that prenatal care is usually delayed and therefore not as beneficial when trying to prevent subpar pregnancy outcomes.

Thus, this preconception health promotion strategy will enable Mexican migrant women to be proactively empowered and increase control over the micro determinants of health by capitalizing on culture (WHO, health promotion). The tradition of informal systems is a sociocultural mechanism that improves women's health by providing a repertoire of resources such as social support, familism, intergenerational knowledge transmission, collectivism, value on personalismo, healthy diet, religion/spirituality, marianismo (selfless devotion), and cuarentena (40 days of sacred and uninterrupted convalescence for baby and mother) (McGlade et al, 2004). Therefore, the role of the individual is to increase adherence to the socio-cultural capital already available and participate in proudly celebrating the protective

factors of culture.

At the professional level, the health care provider's role is to educate the patient about the importance of preconception health and validate healthy cultural practices. Practitioners must focus on reinforcing positive behaviors among the foreign born populations and encourage US born women to adopt positive health behaviors in a culturally appropriate way. Especially regarding the reproductive health of second and third generation Mexican women, practitioners need to intervene regarding smoking, nutrition, heath education, access to contraception, reducing exposure to pollutants and management of chronic conditions (Nazinyan, 2016). Specifically, the preconception wellness measures that should be covered by the practitioner at completion of the first prenatal assessment are: pregnancy intention, access to care, preconception folic acid use, tobacco avoidance, absence of uncontrolled depression, healthy weight, absence of STI, optimal glycemic control, and teratogen avoidance in chronic conditions (Frayne et al., 2016). The implementation of these recommendations will create a safety net of services and a checklist to ensure all patients are covered.

Nazinyan et al. (2016) asserts that preconception health profoundly impacts maternal and child health across the life course. The article encourages practitioners to focus on maintaining positive behaviors among foreign born population and encourage US born women to adopt positive behaviors in a culturally appropriate way.

Preconception health includes:
1. Reproductive health plan
2. Healthy body weight and nutrition
3. Folic acid intake
4. Adequate exercise
5. Abstaining from smoking and alcohol use before pregnancy

Here is an example of preconception health and health care disparities in action: The 2012 Los Angeles Mommy and Baby (LAMB) study was the first study to examine how preconception health status differs by nativity. The study focused on how women engaged or not in certain preconception health behaviors (i.e., tobacco use, multivitamin use, unintended pregnancy, contraception use) and conditions (i.e., being overweight or obese, diabetes, asthma, hypertension, gum disease, anemia). In their race-specific subpopulation analysis USB Hispanics were less likely than their FB counterparts to use contraception prior to pregnancy (AOR 0.58, 95 % CI 0.45–0.74 for Hispanics;). In contrast, USB Hispanic women had a significantly higher risk of overweight/obesity than their FB counterparts (AOR 1.57, 95 % CI 1.23–2.01 for Hispanics;). USB Hispanic mothers were more than twice as likely to smoke before pregnancy (AOR 2.47, 95 % CI 1.46–4.17) than FB Hispanic women. USB Hispanic

mothers were also 1.3 times more likely to not take multivitamins before pregnancy (AOR 1.30, 95 % CI 1.02–1.66) and 2.3 times more likely to have asthma (AOR 2.35, 95 % CI 1.32–4.21), compared to FB Hispanics. Overall, they found that US nativity was associated with an increased likelihood of being overweight or obese before pregnancy. Also US nativity was associated with increased risks of tobacco use and asthma before pregnancy as well as the decreased likelihood of using contraception before pregnancy. USB women and specifically, Hispanic USB women were significantly more likely suffer from asthma, when compared to their FB counterparts. One potential explanation is USB residents are exposed to more environmental risk factors (e.g. outdoor pollution, motor traffic emissions) that are associated with asthma, particularly in urban area.

Lastly the authors state that "it is imperative that clinical, programmatic, and policy efforts address these health behaviors and conditions among immigrants, especially second and third generation Hispanic women, during the preconception period and earlier in the life course by reducing smoking initiation, promoting smoking cessation, improving access to and intake of nutritious food, increasing health education regarding and access to contraception, reducing outdoor air pollutants, and emphasizing management of asthma symptoms" (Nazinyan et al., 2016).

References:

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World Health Organization. (1998). Health Promotion Glossary. Retrieved from http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf. Accessed on January 21, 2017.

Frayne DJ, Verbiest S, Chelmow D, et al. Health Care System Measures to Advance Preconception Wellness: Consensus Recommendations of the Clinical Workgroup of the National Preconception Health and Health Care Initiative. Obstetrics & Gynecology. 2016;127:863-872.

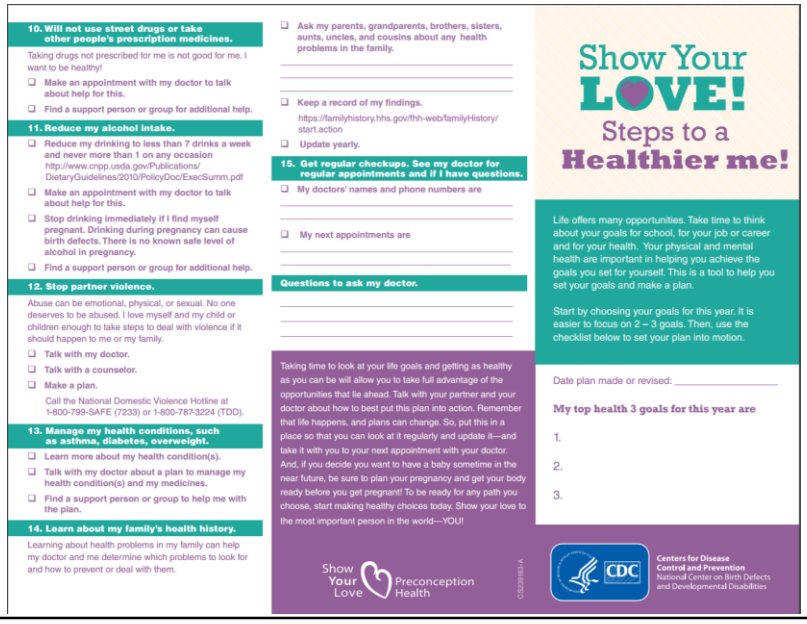
Show Your Love is a national campaign sponsored by the PCHHC "designed to promote wellbeing and support young women and men as they strive to achieve their goals and make healthy lifestyle choices today." Since 2013, Show Your Love is a resource center and consumer social media campaign that "encourages women and men to show love to themselves, their partner, their friends, and future children by taking steps towards a healthier lifestyle and wellbeing." This campaign can capitalize on social media by employing the power of social marketing - a strategy to influence behaviors and attitudes that benefits the greater good. The concept of social marketing focuses on reaching populations intergenerationally in a matter of seconds through peer influences. This method fosters leadership and empowerment from within a community, a sustainable strategy to meet the need for the intervention of respecting, protecting, and fulfilling the human right to health.

To be an Show Your Love Ambassador: you must be 18-29 years old and commit to "model and promote healthy behaviors and life choices online and in [your] community." You will receive gear (look at the examples above) so that you can share your health story/journey in your social channels. Lead by example, today!

To learn more, visit: http://showyourlovetoday.com/jointhelove/

Reference:

Show Your Love. Preconception Health and Health Care. Join the Movement. Available at: http://showyourlovetoday.com/show-love/



10. Will not use street drugs or take other people's prescription medicines.

Taking drugs not prescribed for me is not good for me. I want to be healthy!

- ❑ Make an appointment with my doctor to talk about help for this.
- ❑ Find a support person or group for additional help.

11. Reduce my alcohol intake.

- ❑ Reduce my drinking to less than 7 drinks a week and never more than 1 on any occasion http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/ExecSumm.pdf
- ❑ Make an appointment with my doctor to talk about help for this.
- ❑ Stop drinking immediately if I find myself pregnant. Drinking during pregnancy can cause birth defects. There is no known safe level of alcohol in pregnancy.
- ❑ Find a support person or group for additional help.

12. Stop partner violence.

Abuse can be emotional, physical, or sexual. No one deserves to be abused. I love myself and my child or children enough to take steps to deal with violence if it should happen to me or my family.

- ❑ Talk with my doctor.
- ❑ Talk with a counselor.
- ❑ Make a plan.

Call the National Domestic Violence Hotline at 1-800-799-SAFE (7233) or 1-800-787-3224 (TDD).

13. Manage my health conditions, such as asthma, diabetes, overweight.

- ❑ Learn more about my health condition(s).
- ❑ Talk with my doctor about a plan to manage my health condition(s) and my medicines.
- ❑ Find a support person or group to help me with the plan.

14. Learn about my family's health history.

Learning about health problems in my family can help my doctor and me determine which problems to look for and how to prevent or deal with them.

- ❑ Ask my parents, grandparents, brothers, sisters, aunts, uncles, and cousins about any health problems in the family.
- ❑ Keep a record of my findings. https://familyhistory.hhs.gov/fhh-web/familyHistory/start.action
- ❑ Update yearly.

15. Get regular checkups. See my doctor for regular appointments and if I have questions.

- ❑ My doctors' names and phone numbers are
- ❑ My next appointments are

Questions to ask my doctor.

Taking time to look at your life goals and getting as healthy as you can be will allow you to take full advantage of the opportunities that lie ahead. Talk with your partner and your doctor about how to best put this plan into action. Remember that life happens, and plans can change. So, put this in a place so that you can look at it regularly and update it—and take it with you to your next appointment with your doctor. And, if you decide you want to have a baby sometime in the near future, be sure to plan your pregnancy and get your body ready before you get pregnant! To be ready for any path you choose, start making healthy choices today. Show your love to the most important person in the world—YOU!

Show Your Love Preconception Health

CS328993-A

Show Your LOVE! Steps to a Healthier me!

Life offers many opportunities. Take time to think about your goals for school, for your job or career and for your health. Your physical and mental health are important in helping you achieve the goals you set for yourself. This is a tool to help you set your goals and make a plan.

Start by choosing your goals for this year. It is easier to focus on 2 – 3 goals. Then, use the checklist below to set your plan into motion.

Date plan made or revised: _____

My top health 3 goals for this year are

1.

2.

3.

CDC Centers for Disease Control and Prevention National Center on Birth Defects and Developmental Disabilities

Here are the ready-to-use and approved CDC preconception health messages.

Link:
https://www.cdc.gov/preconception/showyourlove/documents/trifoldhealthierme508.pdf

Goals for a Healthier me!

Changes in insurance plans might mean that you are eligible for some preventive health services, such as screening, vaccinations, contraception (birth control), and counseling, with no co-payment or deductible. To learn more, talk with your health insurance company agent.

1. Prevent unplanned pregnancies.

My decision may change later, but for now, I have decided that I do not want to get pregnant. If I am having sex and do not want to get pregnant, I will

- ❑ **Talk with my partner to share my pregnancy desires and gain support for my plan.**
- ❑ **Select a method of birth control that is effective and fits my needs.**

If I choose an IUD or implant, I don't need to do anything except get my method replaced on time (3-10 years) and talk to my provider if I have any questions or problems with my method.

If I choose other methods, I will use my method correctly and consistently at all times, and make sure that I get more supplies before I run out. I will also talk to my provider if I have any questions or problems with my method.

2. Eat healthy foods.

Planning meals and snacks ahead of time and having the food on hand make it less likely that I will make unhealthy choices.

- ❑ **Make a list before I go to the grocery store, farm stand or market, or neighborhood garden.**
- ❑ **Shop the outside edge of the store where the healthiest food is sold.**
- ❑ **Include plenty of vegetables and fruits.** (*Eat my colors!*)

3. Be active.

Setting aside a time for regular physical activity and being physically active with a friend will help me keep my plan. Fitting in several short 10 minute physical activity sessions throughout the day can help me reach my activity goal.

- ❑ **Try to get 150 minutes of moderate intensity physical activity each week.**
- ❑ **Find an exercise friend.**
- ❑ **Find ways to be active at home and at work.**

4. Take 400 micrograms (mcg) of folic acid daily.

Folic acid is good for my health. Taking it daily will help prevent birth defects of the brain and spine if I should decide to or accidently get pregnant.

- ❑ **Take a vitamin every day unless I eat a serving of breakfast cereal that says it has 400 mcg of folic acid on the nutrition label.**
- ❑ **Place vitamins by my toothbrush or on the kitchen counter or _____to help me remember to take them daily.**

5. Protect myself from sexually transmitted infections (STIs).

Abstinence (not having sex) is the best protection from STIs.

- ❑ **Agree to have sex with only one person who has agreed to have sex with only me.**
- ❑ **Buy a supply of condoms, and use them correctly and every time.**
- ❑ **Get checked if I have been exposed to STIs. http://www.cdc.gov/std/healthcomm/the-facts.htm**
- ❑ **If needed, take all the medicine for the full time as directed by my doctor.**

6. Avoid harmful chemicals, metals, and other toxic substances around the home and in the workplace.

http://www.prhe.ucsf.edu/prhe/pdfs/ToxicMatters.pdf

http://www.marchofdimes.com/pregnancy/stayingsafe_indepth.html

7. Make sure my vaccinations (shots) are up-to-date.

Vaccinations are our best defense against many diseases. Sometimes, those diseases can cause serious problems. I want to protect myself against those diseases.

- ❑ **Remember to get a flu shot every year!**
- ❑ **Check the vaccination schedule before I see my doctor.**

http://www.cdc.gov/vaccines/schedules/easy-to-read/adult.html

- ❑ **Remind my doctor to update my vaccinations.**

8. Manage and reduce stress, and get mentally healthy.

- ❑ **Learn more about getting mentally healthy.**

http://www.womenshealth.gov/mental-health/

http://womenshealth.gov/publications/our-publications/fact-sheet/stress-your-health.cfm.

http://www.webmd.com/balance/stress-management/default.htm

Call National Institute of Mental Health (866-615-6464) for more information.

- ❑ **Be aware of things that cause me stress.**
- ❑ **Make a plan to reduce my stress.**
- ❑ **Find a support person or group, if needed.**

9. Stop smoking.

Smoking is not healthy for me or others around me. I want to be healthy! Second hand smoke is not healthy either. I will avoid being around people when they smoke.

- ❑ **Make an appointment with my doctor to talk about help for this.**

My appointment is _____.

- ❑ **Check out http://betobaccofree.hhs.gov/quit-now/index. html and http://smokefree.gov/**
- ❑ **Call the quit line: 1-800-QUIT-NOW (1-800-7848-669)**
- ❑ **Find a support person or group for additional help.**

The website also offers more checklists that women can use to set goals and be prepared (whether or not they want to become pregnant), which can be shared with their partner and/or their health provider. The checklists are offered in Spanish as well.

Here is the link: https://www.cdc.gov/preconception/showyourlove/buttons-press.html

Now, let's focus on recommendation number 2. A key message to reinforce with the Latinx population is folic acid. Especially because not all grains are fortified and we know that neural tube defects are more common in this population.

According to the CDC, "Hispanic women have a 30-40 percent higher risk of having babies with these birth defects." Despite all the public health efforts to encourage daily folic acid consumption in women of reproductive age, disparities and inequities still exist, "only 21% of Hispanic women report consuming enough folic acid as compared to 41% of white women." The evidence is clear, "folic acid has been found to prevent up to 70% of spine and brain neural tube defects." Therefore, the checklist above is a helpful reminder to be mindful of folic acid intake (through supplements,

enriched breads, rice, and pasta as well as dark, green leafy vegetables).

Besides this checklist, it is important to know that these messages should be omnipresent. In reality, preconception messages can be given during postpartum care, well baby/child care, and during well woman exams.

Another resource aside from the successful Text4Baby campaign, is the LA Health Department's digital initiative. By using text messaging, the health department has capitalized upon technology. "La Familia" is a text message service with the mission of reaching young women with preconception health education in Spanish. "The FAMILIA text messaging program focuses on family planning, active living, maintaining a healthy weight, improving nutrition, reducing stress, and addressing abuse." Participants receive three healthy living texts each week for 3 months.

Here is the link:
http://publichealth.lacounty.gov/mch/ReproductiveHealth/FAMILIA/FAMILIAhome.htm

Reference:

Hispanic Babies are at higher risk of brain and spine birth defects: Mothers who take folic acid can reduce that risk. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/media/subtopic/matte/pdf/CDCFolicAcidMatRelease12-22English.pdf

Doulas: Supporting the Labor of Love

- The word "doula" comes from the ancient Greek meaning "a woman who serves"
  - Trained and experienced professional who provide continuous physical, emotional and informational support to the mother before, during and after birth
  - Classes that support transition
    - From couple to parents
    - Keys to post-partum thriving
    - The 4th trimester

Here is another strategy!

Evidence has shown that doulas- women who are specially trained to be nurturers, educators, and advocates at the gates of life in the context of the family- can help address the current disparity in birth outcomes for Black women and prevent the projected risk due to acculturation for Latinas. Doula Care is defined as “non-clinical emotional, physical and transformational support before, during, and after birth” (Choices in Childbirth, 2016).

Reference:

Choices in Childbirth (2016). Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. *The National Partnership for Women and Families.* *http://transform.childbirthconnection.org/wp-content/uploads/2016/01/Insurance-Coverage-of-Doula-Care-Brief.pdf*

Medicaid Service Rule Revision-42 CFR 440.130 (c)

- Federal level policy
- Key contents
  - Allows reimbursement "for furnishing preventive services recommended by a physician or other licensed practitioner"
- Key advocates
  - Oregon and Minnesota
- Stakeholders
  - Moms and babies
  - From preconception to postpartum

This strategy is not utopian… actually, it is very feasible, and there is a blueprint for action!

"Benefits are so particularly significant for those most at risk of poor outcomes, doula support has the potential to reduce health disparities and improve health equity," which would help alleviate the burden of disease for African American mothers as well as prevent risk of negative birth outcomes for Latina mothers (Choices in Childbirth 2016).

In 2013 there was a Medicaid Service Rule Revision-42 CFR 440.130 (c)- which allows reimbursement "for furnishing preventive services recommended by a physician or other licensed practitioner" (Division of Benefits and Coverage, 2014). This means that reimbursement for preventive services is not exclusive to a physician or other licensed practitioner any more. The change in the regulatory definition is a window of opportunity for doulas and other health educators alike for pregnancy-related services. Unfortunately, the only states which have actually taken advantage of this extension of coverage and reimbursement benefits are Oregon and Minnesota. Despite their avant-garde efforts, these states have been faced with implementation challenges and bureaucratic red tape.

Given that Medicaid already covers “prenatal care through the pregnancy, labor, and delivery, and for 60 days postpartum” we should take advantage of this addendum. Overall, the Medicaid Service Rule Revision is a well-intentioned policy focused on prevention instead of remediation. This is an initiative not always applied given our society’s momentum of instant gratification and short term results focused on gains instead of long-term return on investment. The inherent dilemma about how this policy operates is the lack of implementation since its inception in 2013. True and effective legislative action means implementing policies and procedures for service provision and reimbursement as well as quality control. In this case, the predicament is the lack of implementation of an already existing federal policy that provides reimbursement through public insurance (Medicaid) for doula care.

The CMS final rule published on July 15, 2013 included a change to the regulatory definition of preventive services at 42 CFR 440.130(c) of the federal Medicaid program.
• Previously, preventive services could only be provided by a physician or other licensed practitioner (OLP) of the healing arts for Medicaid reimbursement
• Now, other practitioners, not just physicians and OLPs, can provide and be reimbursed for furnishing preventive services recommended by a physician or other licensed practitioner

Note:

States retain authority to:
– define practitioner qualifications
– ensure appropriate services are being provided by qualified practitioners
– define the preventive services to be provided (within federal requirements at Section 4385 of State Medicaid Manual)
– describe the reimbursement methodology

In terms of action items: “State Medicaid agencies should take advantage of the recent revision of the Preventive Services Rule, 42 CFR §440.130(c), to amend their state plans to cover doula support. States should also include access to doula support in new and existing Delivery System Reform Incentive Payment (DSRIP) waiver programs “ (Issue Brief, 2016).

Lastly, practitioners should link those women not covered by Medicaid with available providers that support moms-to-be in a pro-bono fashion. For example, UNC Hospitals has a volunteer doula program called Birth Partners. For more information, visit: http://www.nchealthywoman.org/BirthDoulas/tabid/3085/language/en-US/Default.aspx

References:

Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Child Health. (2016). Issue brief. Executive Summary: Medicaid and Private Insurance Coverage of Doula Care. National Partnership for Women & Families. Childbirth Connection. Choices in Childbirth. Available at: https://choicesinchildbirth.org/wp-content/uploads/2015/12/DoulaBrief_ExecSummary_FINAL_1.4.16.pdf

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Photo credit: Diego Huerta

Let's Doula this!

- In terms of **cost-savings**, doula-assisted deliveries among Medicaid beneficiaries could save $58.4 million and avert 3,288 preterm births each year
  - Prevention is **cost-effective**: costs of reimbursement for doulas are offset by savings related to lower rates of preterm and cesarean births.
- Cochrane review found that "continuous support in labor" has no adverse effects.
  - MOMS: increases the chance of spontaneous vaginal delivery, less likely to use pain medications or an epidural, reported more satisfaction, and above all had shorter labors.
    - less potentially traumatic obstetric interventions such as caesarean, vacuum, or forceps.
  - BABIES: less likely to have low five-minute Apgar scores

Actually, since the "benefits are so particularly significant for those most at risk of poor outcomes…doula support has the potential to reduce health disparities and improve health equity," which would help alleviate the burden of disease for African American mothers as well as prevent risk of negative birth outcomes for Latina mothers (Choices in Childbirth 2016). At the next level, if prevention is a priority then insurance providers, including, Medicaid, will see a reduction in long-term health costs. The return on investment will be even more powerful when all states implement the Medicaid Service Rule Revision, especially evident through scaling up and measuring collective impact. NC could lead by example and model preventive initiatives for private insurers by reimbursing doulas care services, which would add another winner to the stakeholder table. In terms of cost-savings, doula-assisted deliveries among Medicaid beneficiaries could "save $58.4 million and avert 3,288 preterm births each year." Furthermore, in terms of cost-effectiveness the "costs of reimbursement for doulas are offset by savings related to lower rates of preterm and cesarean births" (Kozhimannil, Hardeman, Alarid-Escudero, Vogelsang, Blauer-Peterson, & Howell, 2016).

A Cochrane review found that "continuous support in labor" increases the chance of spontaneous vaginal delivery, which means less potentially traumatic obstetric

interventions such as caesarean, vacuum, or forceps. Additionally, women were less likely to use pain medications or an epidural, reported more satisfaction, and above all had shorter labors. Regarding the babies and their very first test outside the womb, they were "less likely to have low five-minute Apgar scores," which determines next steps for care as well as reassures the mom and the provider(s) that the baby is physically healthy. Most importantly, the greatest victory is that no harm, complications, or "adverse effects" were identified in the systematic literature review (Hodnett, Gattes, Hofmeyr & Sakala, 2013).

*APGAR stands for Appearance, Pulse, Grimace, Activity, and Respiration. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the doctor how well the baby is doing outside the mother's womb.

The quality of a Cochrane review is undisputed because of their independence without conflict of interests and their reliability in terms of health care decision-making. For the past 20 years they "gather and summarize the best evidence from research" to help clinicians make "informed decisions about treatment." A Cochrane review is similar to a gold standard of practice because their synthesis of information is accessible and concise. So much so that their conclusion regarding doula care is that "continuous support during labor has clinically meaningful benefits for women and infants…all women should have support throughout labor and birth." In this case the findings are generalizable because Cochrane reviewed studies that included 23 trials from 16 countries, involving more than 15,000 women" (Hodnett, Gattes, Hofmeyr & Sakala, 2013).

References:

Hodnett, E., Gates S., Hofmeyr, G., Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews.* 2013;7:CD003766.

Choices in Childbirth (2016). Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. *The National Partnership for Women and Families. http://transform.childbirthconnection.org/wp-content/uploads/2016/01/Insurance-Coverage-of-Doula-Care-Brief.pdf*

Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth,* doi:10.1111/birt.12218

Photo credit: Simón Silva
Titled: "Amor Eterno (Everlasting Love)"

Captioned: “Familia is everything”

What should happen next?

- Implementation and improvement science!
  - Average of 17 years for scientific discoveries to be implemented into clinical practice and community settings (Morris et al., 2011).
- Community Assets
  - Identify cultural gatekeepers
- Resource inventory
  - Identify and connect with stakeholders
  - Leverage points
- Ethics
  - Inter-professional and interagency collaboration opportunity
  - Virtuous cycle instead of vicious cycle

The next step is implementation of what we have learned throughout this training.

The NIH describes that "implementation science is the study of methods to promote the integration of research findings and evidence into healthcare policy and practice. It seeks to understand the behavior of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions." Our challenge today is how to contextually apply what we know in order to maintain and improve, and even scale up healthy birth outcomes. As practitioners we are called to link the science of discovery (the health paradox) to the science of delivery (with structurally competent and patient-centered tools) in order be useful and effective. Good intentions are not enough. If prevention of erosion of the socio-cultural mechanisms is not implemented through structural interventions that support women from pre-conception to postpartum, then these women and the next generations are not realizing their potential.

The formula for success is: Effective innovations X effective implementation X enabling contexts = socially significant outcomes (Fixen et al, 2005). That is why we need 3 things:

1. Implementation science: putting interventions in place by investigating and addressing major bottlenecks (e.g. social, behavioral, economic, management) that impede effective implementation
2. Improvement science: making interventions better by determining a causal relationship between the intervention and its impact
3. Systems science: creating an enabling context for the healthy continuum from preconception to postpartum

Now we most foster a virtuous cycle to address implementation challenges with implementation science. Our outcome objective at this level should seek to bridge the disconnect between a reactive approach to a preventive status quo. Further, by "promoting community, equality, and solidarity" as well as equity, practitioners and their agencies will be positioned as the direct agents of change that foster better quality of life for Mexican moms-to-be and other at-risk populations (Mullaly, 1997).

In order to do so we must observe and map out potential collaboration through doing a community needs assessment that documents assets and resources, not only the deficits and unmet needs.

For example, after 10 years of collaboration with the Mexican Government, I believe they are a cornerstone stakeholder to implementation. In the United States there are about 50 Consulates and one Embassy in Washington, D.C. Every consulate's mission is to protect, document, and celebrate their nationals. This degree of representation allows for visibility, connections, and political capital. The Consulate is funded depending on the unmet needs of the community every fiscal year by the Mexican Government's Institute of Mexicans Living Abroad (IME). Given the unmet need of health care access, the Ventanilla de Salud (VDS) was created with a mission to promote health, educate the community, and prevent chronic conditions as well as acute diseases. The VDS' goal is "the integration of Latinx and their families into the healthcare delivery system in a multicultural and friendly setting, which encourages participants to be proactive and take responsibility for sustaining a holistically healthy lifestyle" (JPMS, 2014). One of their main health programs is universal health care insurance, Seguro Popular, which provides comprehensive health care if the patient returns to Mexico. If for some reason the patient cannot feasibly go back to Mexico, the consulate could finance their return under their repatriation of sick people program "repatriación de enfermos." Further, if a person does not have enough money to pay for their medications, then the consulate can also help finance their needs. This governmental safety net is a formally institutionalized resource available to all Mexican citizens.

Furthermore, to model proactive and preventive behavior and start a virtuous cycle, I propose that the VDS contextualizes in a bilingual and culturally-appropriate manner

the PCHHC's Show Your Love Campaign through outreach during in-house clinic hours, health fairs, and mobile consulates (a service where the Consulate staff travels to serve communities faced with a transportation barriers).

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Photo credit: Cornelio Campos

Conclusion

- Bidirectionality: Social justice is a matter of public health and vice versa
- Importance of being proactive rather than reactive
- Holistic and empowering interventions that include the mother's support system
- As practitioners
  - Learning is a life-long process because culture is fluid
- Mobilization
  - Ownership
  - Co-create ***with*** not ***for*** the community interventions that are sustainable and culturally relevant that promote self-efficacy, mobilization, and ownership.

Let's remember where we came from and where we have been: the epidemiological paradox of Latinx health reveals that "despite higher poverty rates, less education, and worse access to health care, health outcomes of many Latinx living in the United States today are equal to, or better than, those of non-Latinx whites." This paradox questions the determinants allowing these positive outcomes to take place, especially since "Latinx under-use health and mental health services." Actually, "Mexicans report the lowest use of formal medical care. Women report higher use of preventive services than men, but lower use of mental health care." If Mexicans are the most infrequent users of medical services, and women are the lowest among them to use mental health care, then the threat to the sanity of mothers is seriously unaddressed causing avoidable stress (Kingston et al., 2007).

This preventable stress is an opportunity for action for this underserved and marginalized population. Public health is a matter of social justice (and social justice is a matter of public health) because of interconnectivity and history. For example, social policies such as Head Start were created under the assumption that Mexican American and African American children "needed early preschool intervention to overcome the disadvantaging effects of their home cultures." This so called 'cultural deprivation' became the scapegoat and justification for poverty. However, it completely ignored the cognitive advantages of being bilingual and bicultural with achievement-oriented values. For example, "students fluent in Spanish, regardless of nativity, perform better academically across grade levels ranging from

first grade, high school, and through college and graduate school" (Buriel, 2012). Regardless of oppressive practices and policies of exclusion, we must concentrate on what we can achieve right now as well as integratively prepare for the future by building capacity at every level simultaneously. So let's do the right thing… by starting with holistic and empowering interventions that include the mother's support system while advocating at the higher levels with legislators to engage in equitable health system transformation.

Remember that the theories and strategies proposed here are tools for your tool box as well as invitations for further personal and professional development through iteration in order to become the best version of yourself as a health care provider. The ideas presented here require attention in order for growth and progress to manifest in both the short and long terms. These ideals cannot simply be achieved once and then the mission is accomplished. Rather, this curriculum is a call to action that requires praxis in terms of learning, teaching, validating, promoting, fostering, and walking with women and their communities throughout their life course.

Individually and collectively there must be investment and commitment to bridge the gap between surviving and thriving by tapping into our common humanity. Let's strive to provide a healthful and nurturing environment where everyone can equitably achieve holistic health. An interdisciplinary approach that is context-based, history-informed, and community-participatory fueled, is a requirement in the agenda striving to achieve health equity cross-culturally through collective impact. It matters to and for all because a country's health is revealed in the health of its most vulnerable populations.

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